RICHARD S. ADLER, M.D.
Forensic & Clinical Psychiatry
1700 Seventh Avenue, Suite 210
Seattle, WA 98101
(206) 624 - 3800 • OFFICE
(206) 624 - 3801 • FAX

September 28, 2011

Ms. Emma Scanlan
Law Offices of John Henry Browne
821 Second Avenue, Suite 2100
Seattle, WA 98104

RE: US v. Colton Harris-Moore
No. CR10-336RAJ
DOB 03/22/1991

Ms. Scanlan:

You asked me to examine your client, Colton Harris-Moore, and provide a psychiatric expert opinion relevant to Sentencing and/or Dispositional issues.

Colton is twenty years old. In February 2007, after six months on the run from police, he was arrested and subsequently sentenced to three years under the direction of the Washington State Juvenile Rehabilitation Administration. On April 22, 2008, Colton escaped from Griffin Home, an unlocked facility. By July 18, 2008 in the context of the theft of a stolen Mercedes, sheriff's deputies on Camano Island found a camera with several self-portraits of Colton. On November 12, 2008 Colton stole his first airplane. He flew it from Orcas Island and crashed it in Yakima, WA. Around June 2010 Colton made his way from Oregon to Indiana. On July 4, 2010 Colton stole a plane in Bloomington, IN and flew it to the Bahamas. On July 11, 2010 he was arrested off Harbour Island in the Bahamas. Colton was returned to the US and has been at the Federal Detention Center, Seatac, WA for all or most of the time since, awaiting the final disposition of his case.

I am a Board-certified Adult, Child and Adolescent Psychiatrist. I completed a Fellowship in Forensic Psychiatry and hold an appointment on the faculty of the University of Washington School of Medicine. A copy of my resume is provided as an attachment.

All opinions provided here are offered with reasonable medical certainty.

My central findings are:

1. Colton Harris Moore does not have Antisocial Personality Disorder.
2. Colton was an abused youth from an impoverished and chaotic home setting.
3. Colton was exposed to alcohol prenatally.
4. Despite speculation in the mass media that Colton might have a superior IQ, this is not borne out by standardized testing.
5. Rather, Colton has significant life-long neurocognitive impairments, which were never assessed comprehensively.
6. Although Colton was very appropriately placed in Special Education beginning at age 3, he was prematurely and wrongly exited from such services at age 6.
7. The unrecognized and unaddressed neurocognitive impairments put Colton at risk for his pattern of juvenile delinquent (and later illegal) behavior.
8. CPS was involved on numerous occasions, beginning at around age 4. Colton was taken out of the home only once at age ten. This was for three days. All the CPS investigations were closed in short order, ironically, due to mother's lack of cooperation.
9. Psychological tests (particularly the MMPI-2) reflect that psychological harm was done to Colton by the adults in his life. The harm done to Colton appears to meet the definition of Child Abuse or Neglect as contained in WAC 388-15-009.
10. It is likely that Colton, in addition to being abused himself, witnessed Domestic Violence against his mother.
11. Per RCW 26.44.195 such negligent treatment or maltreatment could have formed the basis for the initiation of foster care placement and/or dependency proceedings.
12. <u>What was characterized by the media as the swashbuckling adventures of a rakish teenager, were in fact the actions of a depressed, possibly suicidal young man with waxing and waning Posttraumatic Stress Disorder (following his first plane crash in November 2008).</u>
13. Colton's deficits and problems can be effectively remediated.
14. Colton's instant circumstances can be described as reflecting an "an acute identity crisis of young adult life" according to a preeminent psychologist, Alex Caldwell, Ph.D., who provided consultation.
15. With appropriate interventions Colton has a favorable prognosis.
16. Colton represents a low risk of recidivism.

Interestingly, a recent paperback book, "Fly, Colton, Fly: The True Story of the Barefoot Bandit" [1] contains the following:

> *A Camano Island neighbor, Ms. Bev Davis, said: "He's an amazing kid with some problems that should have been taken care of when he was a lot*

[1] New York: New American Library. Jackson Holtz, 2011. ISBN 978-0-451-23508-4.

> *younger...He was somehow overlooked." Given his circumstances growing up, "I think it's amazing that he's done no worse than he has" (at page 70). She hoped that he would "get a life, medications" and was concerned about what "prison will do?" She added that "I've always loved him and prayed for him and I always will" (page 237).*
>
> *Maternal aunt Sandy Puttmann "placed blame on officials for failing to take him away from her sister."Why didn't they take him away from his mother?" she said. (At page 217)*
>
> *Island County Sheriff's Detective, Ed Wallace, considering that Colton had provided authorities with a 'treasure trove of evidence,' concluded that "He's not some criminal mastermind...A criminal mastermind doesn't leave us this [kind of evidence]" (page 91).*

This evaluation consisted of two separate 1:1 interviews, collateral interviews, numerous tests, and extensive document review. Colton's life history, like the instant offenses, has an epic quality to it. Despite the apparent length of my report, an effort has been made to focus on the most relevant information and issues at the risk of having edited out some less essential details.

Given the confirmed history of prenatal alcohol exposure, I wished to conduct a complete evaluation for Fetal Alcohol Spectrum Disorders, including a physical examination.[2] Despite repeated requests to authorities at the Federal Detention Center – Seatac, I was not granted permission to enter the facility with my medical equipment. This precluded my doing a physical examination on Colton.

Neuropsychological screening tests were administered by my graduate psychology student, Ms. Chris Rebholz. A forensic neuropsychological evaluation was subsequently requested from Craig W. Beaver, Ph.D, ABPP. The evaluation was obtained to further pursue what were (surprising) abnormal results on the screening neuropsychological screening tests.

Dr. Beaver was tasked with addressing: (1) whether these initial results were the result of malingering, or (2) whether Colton did have significant neurocognitive impairment. Dr. Beaver administered approximately twenty (20) additional tests. Dr. Beaver's work verified that, in fact, significant neuropsychological impairments were present. Further input was requested from Paul D. Connor, Ph.D., a widely-recognized authority in the Neuropsychology of Fetal Alcohol Spectrum Disorders (FASDs).

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[2] Brown NN, Wartnik AP, Connor PD, Adler RS. A Proposed Model Standard for Forensic Assessment of Fetal Alcohol Spectrum Disorders. J Psychiatry & Law. 38: 383 – 418, 2010.

The data (i.e. interviews, records reviewed, etc.) upon which I relied will be provided separately.

The information in this report is provided in the following order:

1. Home/Social/Developmental History,
2. CPS Involvement,
3. Educational History,
4. Neuropsychological Testing,
5. Personality Testing (e.g., Minnesota Multiphasic Personality Inventory – 2),
6. Prior Evaluation of psychologist Delton Young, Ph.D., June 2007,
7. Diagnosis,
8. Overall Summary,
9. Risk for Recidivism,
10. Recommendations,
11. Prognosis.

Prior to each interview, Colton and all others were provided with appropriate notifications regarding the nature of the contact and the limits upon its confidentiality.

HOME ENVIRONMENT/SOCIAL HISTORY:

Colton Harris-Moore was born at the Skagit Valley Hospital and Health Center in Mount Vernon, Washington, on March 22, 1991 by a planned Cesarean section. His mother, Ms. Pamela Kohler, was thirty-nine years old at the time. Had Colton not been delivered by Cesarean section, his expected due date was April 1, 1991. Thus, he was delivered at an estimated 39 weeks. The hospital's Delivery Record reflects that mother reported that she was a smoker.

Colton's mother identified Gordon Moore as Colton's biological father. Birth records reflect this also. [Colton, however, doubts that Mr. Moore is his biological father based on his lifelong troubled interactions with Gordon Moore].

At birth Colton was only at the 5th percentile for weight (6 pounds, 4 ounces) and at the 10th percentile (18 ½ inches) for height. His newborn status was excellent, with the exception of appearing not quite "pink" at 1 and 5 minutes after birth. Developmentally, the examination was consistent with that of a 36 week gestational infant. Discharge teaching was done with the mother only.

At age three months he was hospitalized for surgical repair of right-sided inguinal and umbilical hernias.

By ten months he was 95th percentile for weight. He was noted to have "high milk intake," for example three 8-ounce bottles of whole milk per day plus milk at mealtimes.
DSHS provided child-related services to the family before Colton turned one year old. Ms. Kohler told me that this was related to the provision of childcare while she was enrolled in school.

At twenty-one (21) months old the pediatric records already reflect "a lot of acting out behavior and temper tantrums while in the office." It was reported that Colton "seems to challenge his father when father is home."

Pediatric records indicate that around age two and a half he was now "very well developed and nourished," but "quite frightened of the examination…only using the most rudimentary of language…cry is of a rather monotonous sort…question of some behavior problems and developmental delay."

By age three, records indicate that Colton's "speech is a concern to mother, in fact she has an appointment next week to have this evaluated." Mother was documented to be unemployed around this time.

Gordon Moore was in and out of the home during Colt's first four years. The parents never married. As a result, Colton and his mother have different last names. When interviewed by Dr. Beaver, Colton reported that his mother gets Social Security Disability and some other kind of disability for a "broken back." He reports this was because of the physical abuse she suffered at the hands of Gordon Moore. Colton believes that his mother has never been married (even to Mr. Kohler –see below).

Colton told Dr. Beaver that he thinks his biological father might be Gordon Moore, but that he is not certain. Colton does not know if Mr. Moore is alive or dead. He notes his last contact with him was around age 13 or 14 when Mr. Moore is thought to have left for Las Vegas. Colton noted that Gordon was an alcoholic and a "rough guy." He never really worked or had a career. He reports they did some things that were fun, such as going camping. However when he drank, he typically would go on a "rampage" and was very physically abusive to both him and his mother. Colton also noted he had a lot of legal problems in part related to his drinking and aggressiveness.

Mr. Moore's criminal record was reviewed for me by consultant psychologist Loreli Thompson, Ph.D., who was previously an officer and thirty-year veteran of the Lacey, WA Police Department. Dr. Thompson reported that Mr. Moore had twenty-six (26) arrests between 1989 and 2003. Of these, there were twelve (12) convictions that took place between these same years.

At around age 4, Colton's mother is reported to have married Mr. William Kohler, who was a heroin addict.

Per Dr. Thompson, Mr. Kohler's criminal history includes twenty-eight arrests and fourteen convictions from 1987 to 2000. There were also thirty-four criminal court actions in six counties from 1982 to 2002, some of which may be duplicative. Among Mr. Kohler's convictions are: Assault 4th Degree, Burglary – 2nd Degree, Controlled Substance Violations, Theft and Driving While License Suspended.

Two of Mr. Kohler's convictions were for Domestic Violence – Assault 4th Degree (1995 and 2003). Many of the charges were for Driving under the Influence, Driving While License Suspended and in 1990 he was convicted of being a Habitual Traffic Offender. There was also a conviction for Hit and Run (Attended).

I did not have the benefit of Department of Corrections records to better understand "who was where" at any point in time.
Based on records obtained from officials in Oklahoma, Mr. Kohler died on August 17, 2002, when Colton was almost 11 ½ years old. Mr. Kohler was forty-nine years old at the time.

The cause of death, in part, was described as being due to the "toxic effects of promethazine" which was recovered in the femoral blood. His death was characterized as occurring "under suspicious circumstances…violent, unusual or unnatural." The investigator's narrative reflects that Mr. Kohler had "recently gotten out of prison and was traveling across the country to start a new life." However, records reflect that he had an appointment to see a gastroenterologist in Washington State on September 27, 2002. Mr. Kohler, it states, "had been incarcerated for approximately seven years according to [his] uncle." Prior to his death that evening he appeared to be "acting dizzy." Autopsy revealed an enlarged heart, an enlarged liver and spleen, and a history of Hepatitis C, consistent with intravenous drug use.

Ms. Kohler told me that Colton received SSA (Social Security benefits) after the death of Mr. Kohler, even though he was never formally adopted, nor was paternity established.

The sudden death of Mr. Kohler was just one of numerous losses and/or exits of significant persons from his life, including his maternal aunt, his maternal uncle and Mr. Gordon Moore. See below.
A chart note dated January 21, 1998 indicated that Colton was seen after he "hurt his left ankle yesterday but he doesn't remember how."

Medical records indicated that on January 23, 1999 he was seen for a "human bite thru shirt yesterday" on his left arm. There was no further information included about the origin of the bite.

Around age nine, medical records indicate that mother told a doctor that Colton "seems to have a high metabolism and is always too hot." [Subsequent testing revealed an elevated thyroid hormone level (T3) but it appears this was not addressed].

At age 10 (2001) Colton was seen at the Skagit Valley Hospital Emergency Room for a laceration of his left leg below the kneecap that was 4 cm deep. It was reported that "he slipped and fell landing on and injuring his left knee. However, his pants were not torn." The nursing note indicated that "Parents with Alcohol on Breath and arguing with each other."

On May 21, 2003 it is recorded that Colton "fell off some stairs two days ago when he was throwing rocks at his dad." He was diagnosed with a right-sided torus buckle-type fracture of the distal radius just above the growth plate.

On May 7, 2004 an Emergency Room Visit occurred for a left leg laceration produced by an accident with a hatchet. He came to the Emergency Room approximately 24 hours after the time of the injury (1:30 p.m.). May 6, 2004 was a Thursday.

Colton stated that his mother has severe alcohol abuse problems. He noted that she drinks on at least an every-other-day basis, and she drinks to get drunk. He reported that she may have worked in the past but has not worked for a long time. He thinks he was in fifth grade the last time she had a job.

INTERVIEW OF COLTON'S MOTHER, MS. PAM KOHLER, MAY 30, 2011:

At her request, Ms. Kohler was interviewed at the Buzz Inn Steakhouse in Arlington, WA. In a prior phone conversation on May 29, 2011, Ms. Kohler initially told me she had decided against participating in a previously-arranged interview, for fear that Colton's lawyers had sent me (in her words): "to make it out to be all my fault." After our phone conversation she agreed to meet with me.
Ms. Kohler was cooperative at the outset of our meeting. Rapport diminished quickly, however, when I did not agree with her opinions. The tenuous nature of her participation required that I prioritize my questioning.

As a whole, her reliability as a historian was questionable. For example, she told me that Colton 'drank a gallon of whole milk every day' since he was very young.

Ms. Kohler appeared to maintain the seeming contradictory view that: (a) there was nothing wrong with Colton other than his having not been disciplined (i.e. "spoiled"), and (b) he had some problem with his "synapses." In fact, she told me that she had requested since Colton's

early school years that his pediatrician refer Colton for a "brain scan". She made a similar request to Juvenile Court in a June 27, 2007. The letter read:

> *"Colt has had mental problems since about age 2...He does things without thinking of the end results... [I asked his doctor, Johana Wilcox] to refer us to a hospital in Bellingham for a brain scan and she refused...He started hanging around the wrong type of friends and this made things worse for him...This boy has had many disappointments all his life. His stepfather died and our dog [at the same time] and this had severe effects on Colt and I."*

Ms. Kohler provided me with an account of Colton's developmental history. She reported that she had difficulty conceiving over the course of five years, and had seen a fertility specialist. She had surgery for (uterine) fibroid tumors and a year later got pregnant. Colton was the product of a planned and wanted pregnancy.

Ms. Kohler recalled that she gave a birthday party for her older son at the end of July, 1990. She recalled feeling nauseous, but stated that 'it never occurred to me that I was pregnant.' She reported having "five or six beers" at the party. She asked her doctor about this and was told "not to worry about it."

Ms. Kohler seemed to convey that she drank 2 – 3 beers a day and upwards of 6 beers each weekend day prior to learning she was pregnant. She also smoked a pack a day of cigarettes a day. She reported she did not drink or smoke once she learned she was pregnant. Once I conveyed my thoughts regarding the possibility of fetal alcohol effects in Colton, Ms. Kohler seemed to deny anything other than the singular episode of drinking at her son's birthday party in July 1990.
Ms. Kohler indicated that she was one to two months along when she found out that she was pregnant. She presented herself to Stevens Hospital, but they advised that she simply use a "home pregnancy test." Ms. Kohler was 40 years old at the time. Her doctors conducted an amniocentesis and one or more ultrasounds.

Ms. Kohler reported that her office and the bathroom at the Navy facility on Lake Washington (where she worked) did have asbestos. It was eradicated in part during the pregnancy, but she herself was not tested for asbestos exposure. The pregnancy was otherwise unremarkable; she was taking no medication except vitamins. She denied any use of illicit substances.

[Colton has an older half-brother who is twenty years older. The two "don't even really know each other." Ms. Kohler told me that she didn't want anyone bothering her older son, since he has a head injury. This occurred 11 – 12 years ago, and resulted from a fall from a roof. Her son

worked as a roofer. He now has "anger issues" and she noted that she has a hard time understanding his speech, especially when he is upset].

Colton was delivered by scheduled Cesarean section in light of his mother's prior uterine surgery. Ms. Kohler indicated that the birth was uneventful. She reported that Colton was 21" in length, but she could not recall his birth weight. He was unable to breast feed at the hospital and was thus started on bottle feedings. Colton was not colicky.

Ms. Kohler described Colton as a "happy baby" who was "easy" and 'cuddly' as a newborn. She told me however that he "required a lot of attention" later, but was unable to provide any clarification about what she meant. She reported that he slept through the night "right away… walked early" and also "talked early" (the latter seems contradictory to his documented speech delays). On the weekend of Father's Day 1991 he underwent emergency surgery for an umbilical hernia. Ms. Kohler reported simply that Colton was "out of diapers as soon as possible."

Colton's mother didn't know very much about her son's history of friendships. She said that he "never brought any home." Although she would not say he had a clear "best friend," she recalled that Colton had a friend in grade school named "Scotty" for two or three years.

When asked about particular talents, hobbies and interests, Colton's mother told me about his artwork. She indicated that he drew airplanes every day, starting some time around age 4 – 6. He also played with balsa wood airplanes, eventually making his own from a large sheet his mother purchased. He also had a well-developed interest in animals and birds. The family had chickens and he "named them all," and had a very detailed knowledge of each bird.

Ms. Kohler had no information about when Colton started puberty. Regarding romantic and sexual development, she stated that there were "a couple of girls he would talk about…but he didn't talk to me too much about girlfriends."

Ms. Kohler reported that her son was "usually pretty happy," emphasizing that he was notably "depressed on Strattera right away" and the medication was discontinued within two weeks. [This is in direct contradiction to psychiatric records that thoroughly document a nearly miraculous response to Strattera optimized to a dose of 60 mg per day. It was regarded by Ms. Kohler as so helpful that she considered suing DSHS so that it would be provided for her son].

She described Colton as having long-standing problems with sleep onset up to 2 – 3 hours each night. She reported that his appetite was generally good and that he had "a lot of energy." She described his mental faculties (i.e. memory, concentration) as "good." She did note that he was impulsive, however, and referred to an instance when he climbed a tall Hemlock at the home one day when an in-home therapist was visiting.

She denied any knowledge of suicidal ideation and/or homicidal ideation. She stated that she knew of no auditory hallucinations experienced by Colton. Both she and he did experience "seeing" his stepfather Mr. Bill Kohler "once and a while," which was "comforting." It was not so much as a true visual hallucination, however, as "a feeling you get."

Colton's mother denied any history of physical abuse experienced by Colton, stating: "but the police report will say it did [happen]." She mentioned that Colton was throwing rocks "the size of baseballs at his dad," because he didn't want to barbeque and this precipitated the events described in official reports.

As it relates to harm Colton did to others, she pointed to her forehead, where she said there was a scar and explained that a door at home had hit her when Colton pushed through it during a heated argument.

When asked about sexual abuse Colton may have experienced, she told me that she received a letter related to a "sex abuse allegation" made against a guard at the Green Hill Juvenile Correctional Facility. The letter conveyed that the allegation was determined to be "unfounded."

Late in the interview I asked Ms. Kohler to complete the Minnesota Multiphasic Personality Inventory - 2 to assist in (a) understanding her response (i.e. reporting) style, and (b) obtaining objective data regarding her personality and emotional functioning. Ms. Kohler declined. She did complete the BRIEF-A, Informant Version, which is described below and concerns her view of Colton's behavior.

INTERVIEW OF COLTON'S MATERNAL AUNT, MS. SANDRA PUTTNAMM, JUNE 1, 2011:

Ms. Puttnamm is sixteen months older than her sister, Colton's mother. She reported that her sister was drinking alcohol at age sixteen, and was a problem (daily) drinker for quite a long time before conceiving Colton. She characterized herself as "ninety-nine percent certain" that her sister Pam was drinking prior to learning she was pregnant with Colton. They were in frequent contact by phone.

Although Pam Kohler denied drinking and smoking after she knew she was pregnant, Sandra has a clear recollection of Pam's continued cigarette smoking, and highly suspects that drinking alcohol continued also.

Sandra looked after Colton when his mother was working, from the age of five weeks to about

age 18 months. [3]

Sandra had been concerned for a long time about possible effects of prenatal alcohol exposure on her nephew, but Colton seemed to be a normally developing infant.

After doing the workweek daycare for Colton, she would see Colton approximately monthly until age three or four. After this, Sandra did not see her nephew until age 13 or 14

Sandra said that Colton told her he was living with a couple on Whidbey Island both times he was on the run from authorities. Sandra said that she called the Island County police to provide the woman's first name, and other identifying information.

Sandra spontaneously told me that her nephew at thirteen was clearly "depressed...you could see it from how he reacted with his mother yelling at him." She told me that he was interested in and kind to her animals including a dog, cat and horse. She added that he does not have a violent nature, and "could not and would not have fired a shot."

She recounted how he'd come to her property and used his metal detector to hunt for parts of a World War II-era plane that had crashed. She confirmed that he had been "obsessed" with planes from a very young age, and she impressed by the knowledge he had about the parts he found, as well as information about various rocks.

She told me that she is very strongly bonded with Colton. Colton called her while on the run more or less monthly. She estimated that there were ten calls in total, usually lasting thirty to forty-five minutes each. Sandra urged Colton to turn himself in, and offered to help him do that, but he told her repeatedly that he was afraid that he'd be harmed by the authorities. His aunt offered to go with him to the Seattle Police Department.

INTERVIEW OF MATERNAL UNCLE, MR. ED COAKER, JUNE 3, 2011, 1:30 - 1:50 P.M.:

Colton's maternal uncle, Mr. Ed Coaker, is sixty-six years old and retired. He is three years older than Colton's mother.

Mr. Coaker conveyed that he would frequently "hang out" with his sister for the period of time six to eight years preceding Colton's birth and for two years following it.

[3] Sandra denied Pam's report of Colton being unduly sedated after being watched by his older brother's wife later in his first year. Sandra told me, however, that this woman was a drug addict.

Mr. Coaker felt that his sister was drinking six days out of ten. He said that "at least once a week" throughout the pregnancy he himself was at bars drinking with her.

When asked specifically if she was drinking, he replied "sickingly so," adding that "the pregnancy didn't affect her drinking whatsoever." He stated that she was "usually drinking beers" and would "drink until she couldn't hardly walk." He also confirmed that she continued to smoke cigarettes throughout the pregnancy. He denied any knowledge of his sister using other harmful substances.

Mr. Coaker emphasized the negative influences that occurred after Colton's birth. He characterized his sister as having "no morals whatsoever," stating that Colton has a "disgusting person for a mother."
He is very upset with his sister. Mr. Coaker told me that ten to twelve years ago his son, nineteen at the time, was in some fashion staying with Ms. Kohler. Mr. Coaker went to the trailer and found his son on the couch unresponsive. Emergency services and police were called to the home and it took them twenty to thirty minutes to revive the young man. Colton was there, but he was sent to his room by his mother. Mr. Coaker was so upset by his sister's involvement in this matter that "on my way home [he decided that she] doesn't exist in my world." He has had no contact with her since then.

Mr. Coaker feels guilty that he did not do more for Colton, adding that Colton "had no childhood." He related that his sister would berate the boy for spilling milk, saying "I wish you had been born dead."

Mr. Coaker said that Colton "should be punished, but whatever time Colton gets in jail, his mother should be across the hall."

CPS INVOLVEMENT:

CPS was first involved in Colton's life at age 4 (1996), related to an anonymous report of physical abuse by his mother. Records indicated that Ms. Kohler could not be located and that there was no intervention by CPS.

CPS became involved again when Colton was 10 (in 2001). This was related to concerns about Colton's physical abuse by his mother's boyfriend, Van Jacobsen. Colton spent 2-3 days in a "receiving home." CPS determined that Mr. Jacobsen, but not Ms. Kohler, was alcohol dependent. Mother told CPS that she ended the relationship, she declined services and the case was closed in less than two weeks.

In 2003, Mr. Gordon Moore assaulted Colton physically. Police arrested Mr. Gordon Moore, who was wanted on warrants. Shortly thereafter, Colton was taken for services at Compass Mental Heath. CPS became involved. Mother refused services, but accepted services focusing on Colton. Within four months from the time of the assault, Ms. Kohler refused services and the case was closed.

Within four months (December 2003), in the course of Colton's Compass Health counseling, Ms. Kohler acknowledged her problems with alcohol, was referred for treatment, but did not follow through.

In 2004 there was some physical altercation between Colton and his mother. CPS was notified, but the case closed, considered as "information only."
In 2004 Colton told his counselor at Compass Health that his mother's drinking was a significant family problem. Records reflect that Ms. Pam Kohler told a staff member: "I'm not going to stop drinking for no 12 year old." About two weeks later a progress note by Physician's Assistant, Ms. Susie Wilson reflects that Ms. Kohler refused to see her drinking as part of Colton's problems.

Records provided include a CPS Closing Summary, dated March 5, 2004.

Records reflect a possible probation-related report of Colton assaulting his mother on March 23, 2004 (at age 13). The case was closed by CPS on March 31, 2004.

CPS referred the family for specialized services (FRS) on May 12, 2004, but the CPS case was closed on July 22, 2004 because mother was not cooperative.

A July 26, 2004 note indicates that mother had refused treatment recommendations made by Compass Health. Attendance at Alateen was being suggested for Colton.

In May 2005, Ms. Kohler pursued an At Risk Youth (ARY) petition due to her report of Colton's assaults on her. CPS was again involved in facilitating this, but Ms. Kohler did not follow through. By October 2005 Family Reconciliation Services (FRS) ended.

A police report dated December 5, 2005 (age 14) concerns a report of physical assault by Colton towards his mother.

An anonymous complaint was made at Green Hill regarding unwanted sexual touching by staff. CPS investigated the complaint. Colton denied that he had made the complaint. The issue was deemed to be without any basis.

EDUCATIONAL HISTORY:

Colton attended a special needs preschool beginning at age 3. He was classified as "Developmentally Delayed" and Colton qualified for Special Education Services.

Colton had difficulties in: (1) pre-academic skills, (2) maintaining appropriate play with peers, (3) pronoun usage, (4) specific word sounds, and (5) social communication/voice quality.

A Teacher Report dated May 18, 1994 indicated that the only color Colton could say was "black." One of the identified educational goals was for Colton to "use words in an appropriate way to express needs, wants, feelings and frustration and refrain from aggressive behavior."

No IQ testing appears in any of the school records. Furthermore, although consideration of Social/Emotional factors is typically a component of Special Education/Multidisciplinary Team (MDT) evaluations, no such assessment is reflected in the school records.

Colton was reevaluated on March 19, 1997, approximately three years after his initial assessment. It was decided that he no longer qualified for Special Education Services. He was mainstreamed beginning in Kindergarten.

Colton's performance deteriorated from one school year to the next.

In the area of attendance, in 1st, 3rd and 5th grades he had 23, 21 and 34.5 days absent respectively. In 5th grade he was tardy twenty-one (21) days. Despite this, and his prior history of Special Education enrollment, school records do not reflect any referrals for reevaluation/services.

- Colton's 1st Grade Report Card noted that "Colt needs to continue to work on listening, following directions and keeping hands to himself as Colt has difficulty with self-control" (January 1997).
- In 2nd Grade his Report Card reflected a much larger number of behaviors identified as needing improvement: working independently, working cooperatively, following oral directions, following written directions, assuming responsibility for his actions, self-control, following playground rules, following classroom and school rules. By the 4th Quarter he is noted to "struggle with math" (June 1999). None of the five homework assignments were turned in that quarter.
- Colton's behavioral problems were even more pronounced by the end of the 3rd Grade. Each of the following had become bad enough to be called an "Area of Concern" - demonstrates respect for adults, cooperates well with others, follows class rules, assumes responsibility for actions.

- On the Iowa Tests of Basic Skills, administered in 3rd grade (March 2000), Colton's Math Total (National Percentile Rank) was at the 13th percentile, and his Reading Total was at the 21st percentile. Notable was his score on a subtest of Problems and Data Interpretation. His score on "Strategies," was a relative strength, standing out at the high end of average.
- Colton participated in the Success for All Wings program in 3rd grade. He was noted to have 'problems being kind to his partner on some days.' He was working hard on his written answers, and completed his work on time. Despite this, his instructional level by year's end was 2.2, compared to 2.1 in the first quarter.
- By the end of 4th Grade, he had reached the beginning 4th Grade level in Reading.
- On the Washington Assessment of Student Learning (WASL) Test, he failed to pass in the areas of: (1) Reading, (2) Mathematics, and (3) Writing. The only test that he did pass was Listening.
- Colton's 5th Grade Report Card reflects persistent problems in the area of "Social Development." His final quarter grades in all areas were F's, but his Math grades were consistently poor throughout the year (i.e., D+ to F's). By the end of 5th Grade, he had achieved only a 4.5 Grade Instructional Level in Reading.
- In 6th Grade, his first year at Stanwood Middle School, Colton got very poor grades, resulting in a Final GPA of 0.714 (D-). A relative area of strength was a C obtained in Science. The Iowa Tests of Basic Skills administered in March 2003 resulted in the following scores: Reading Total = 36, Language Total = 13, Math Total = 23 (National Percentile Ranks).
- Colton was absent and did not take the Spring 2004 WASL Test in 7th Grade.

Discovery includes signed Release of Confidential Records Consent forms, which permitted both the Snohomish County Juvenile Court/Probation Department (2003) and the Juvenile Rehabilitation Administration (2005) to obtain this information. It is unclear from the records whether (1) they requested the material and/or (2) reviewed it. JRA records do not contain any mention of Colton's significant early developmental delays, however.

MENTAL STATUS EXAMINATION:

The Mental Status Examination is a standard inquiry regarding the examinee's current and recent functioning. It includes an exploration and description of the evaluee's examination behavior, his manner of interacting and self-reports regarding mood, mental processes and basic biological functioning (e.g. sleep, appetite, energy).

At the time of the first interview, Colton indicated that he was not told about the visit in advance, and furthermore it appeared that he was unaware of my participation or role in his matter. He was nonetheless cooperative and pleasant from the outset.

Colton was patient and respectful while we waited for the corrections officer to permit us to use an interview room.

Colton informed us that the FDC's alarm system was being repaired and that the auditory and strobe light alarms had been going off regularly since 5:00 a.m. Despite this, he displayed an "easy going" and cheerful manner. Fortunately, the auditory alarm stopped at 2:00 p.m. and the strobe light stopped around 2:20 p.m.

Colton is notably tall (approximately 6' 5") and appears approximately 3 to 5 years younger than his age in overall manner. He was appropriately dressed in detention garb and groomed. Eye contact was direct. His motor activity was within normal limits and there was no indication of tics, twitches or other abnormal involuntary movements.
Colton demonstrated an adequate understanding of the nature of the charges he is facing as well as relevant issues concerning the legal process, in particular the rudiments of plea agreements. In light of this and the absence of concerns from his lawyers regarding Competency to Stand Trial, we proceeded with the examination.

Colton did not elect to take any breaks during the evaluation, even when it was offered. His overall manner was that of earnestness. He was forthcoming and there was a notable absence of guile. On one occasion he demonstrated a subtle sense of humor.

When asked whether he had ever noticed some of the difficulties in "real life" elicited by the various tests, he indicated that he only "started thinking about it "[i.e., short-term memory problems] in the last six months. He could not give an example of such problems. However, Colton stated "I told the teachers this is not making sense to me" frequently. When asked why he thought he might have this problem [i.e., short-term memory], he reported that he lived in an old house, which might possibly have had lead paint, until age 14. [There is also a possibility that the trailer he grew up in is affected by mold due to a history of it not being watertight].

NEUROPSYCHOLOGICAL SCREENING TESTS:

On May 24, 2011, Psychology doctoral-candidate student Ms. Chris Rebholz administered psychological screening tests to Colton in my presence.[4]

Colton was administered the following:

[4] The purpose in administering such tests was to determine if further assessment was needed (as reflected in my May 5, 2011 'Declaration Supporting Allocation of Federal Funds for Professional Services' at p. 2, #6).

- Word Memory Test,
- Wechsler Adult Intelligence Scales, Fourth Edition (WAIS-IV), and,
- Repeatable Battery for the Assessment of Neuropsychological Status (RBANS).

The results were compared with those generated by psychologist Dr. Delton Young, Ph.D. in May 2007 and shown below.

WORD MEMORY TEST (WMT)

The WMT Test is an external test of response style used to assess whether appropriate effort is being demonstrated by the examinee. Mr. Harris-Moore produced a score of 95%, suggesting that he was making adequate efforts to attend to the tasks, supporting a conclusion that other test results can be viewed as valid.

WECHSLER ADULT INTELLIGENCE SCALES, FOURTH EDITION (WAIS-IV):

WAIS-IV index scores, which are fully "interpretable", consist of:

- Verbal comprehension (VCI): 103
- Working memory (WMI): 92

The following WAIS-IV index scores cannot be interpreted as a unitary construct due to statistically significant differences in the results of the subtests composing the scores:

- Perceptual Reasoning (PRI) - estimate: 100
- Processing Speed (PSI) - estimate: 89

There are statistically significant differences in Mr. Harris-Moore's WAIS-IV index scores such as the VCI (103) and the WMI (92). The VCI (103) and PSI (89) are also significantly different, but the PSI due to variability within it, cannot be interpreted as a unitary construct. Because of the prominent "scatter" within the subtests, a reliable Full Scale IQ cannot be derived. Explained most straightforwardly, when there is considerable difference between scores within a given category, simply adding them up and then calculating an average will not result in a true, accurate or reliable number.

RBANS TEST RESULTS:

Colton's RBANS results also show significant levels of difference between scales. His scores are:

Index	Scaled Score	Percentile
Immediate Memory	65/81 *[5]	<1 / 10
Visuospatial/Constructional	102	55
Language	85	16
Attention	85	16
Delayed Memory	91	27
TOTAL SCORE	81/84*	10 / 14

Specifically, the Visuospatial/Constructional scale (102) is more than 1 standard deviation greater than the: (1) Immediate Memory (65/81), (2) Language (85), and (3) Attention scales (85).

Colton's WAIS-IV and RBANS index scores showed statistically significant differences when looking at various indicators of his cognitive and neuropsychological functioning.

The RBANS, in particular, functions as a "screening test," meaning that it is used to ferret out abnormalities, and if present, prompts further inquiry and examination. Due to these statistically significant differences, additional neuropsychological testing was recommended, and Craig W. Beaver, Ph.D. was asked to administer a more extensive neuropsychological test battery.

NEUROPSYCHOLOGICAL EVALUATION, CRAIG W. BEAVER, PH.D.:

The following specific consultative questions were posed to Dr. Beaver, and are provided below. The questions are followed by Dr. Beaver's response, which I have summarized from his report. Dr. Beaver has reviewed this section of my report and endorsed it as accurate.
Question #1: On prior testing that was administered (i.e., RBANS and WAIS-IV), was Colton exerting his full effort? Can those findings be relied upon?

[5] * The Immediate Memory index includes the List Learning subtest. During the administration of the List Learning subtest, Mr. Harris-Moore reported that he had misunderstood the original instructions. Because of this circumstance, the scaled scores were calculated two ways: (1) using the actual results of the List Learning subtest, which yielded an Immediate Memory scaled score of 65, and (2) assuming that had correctly understood the instructions to the List Learning subtest, which resulted in a (higher) Immediate Memory scaled score of 81.

Dr. Beaver noted that during the May 2011 testing administered by Ms. Rebholz, the Word Memory Test results were consistent with adequate effort.

In Dr. Beaver's own examination of Colton, he relied upon two internal validity measures and an additional external validity test. Since all three were passed favorably, Dr. Beaver concluded that all the neuropsychological test results could be taken as valid and reliable. He also noted the consistency in results between the various testing sessions from 2007 to present, which further reinforced the likely validity of the results obtained.

Question #2: Is it likely that the neuropsychological problems found on testing represent persistence from childhood?

The IQ testing administered by Chris Rebholz showed that Colton has "average intellectual abilities," but additional in-depth examination revealed that there are "significant select neurocognitive deficits," as predicted by the RBANS results.

Dr. Beaver found that Colton has the following problems:

- Verbal Fluency – problems organizing and verbally expressing his thoughts in a quick and concise manner,
- Mathematics Learning Disorder,
- Attention/Concentration Problems – initial impulsive responding,
- Problems with initial processing of new information – especially visual information.

Dr. Beaver felt as if Colton's current problems with Verbal Fluency likely represented a persistence of those Speech and Language problems for which Colton received Special Education services in preschool.

Similarly, Colton's current poor performance on the Wide Range Achievement Test's mathematics section is consistent with both his academic records and Colton's self-reported struggles in this area.

Colton's prior treatment records reflect an early concern about Attention Deficit Hyperactivity Disorder (ADHD), and at least one medication trial on Strattera for this problem. Although Dr. Beaver did not feel Colton had "classic" ADHD, he did highlight the presence of meaningful problems with attention and impulsivity.

Going further, Dr. Beaver concluded that the neurocognitive difficulties found on testing are the kind that would result in academic problems even in the absence of any behavioral issues. Dr. Beaver noted that such verbal fluency and memory problems would make school "rather frustrating."

He commented that he found it: remarkable that a more comprehensive neuropsychological examination…was not completed early on. The pattern of his behavioral difficulties, early special education and speech problems should have been a warning sign' prompting further study and doing so would have potentially helped Colton.

Question #3: Considering that the clinical picture does not seem to be like classic ADHD like, would a trial of stimulants (with pre- and post-medication CPT-IIs) be useful?

With regard to the issue of Colton's possible "chronic underlying depression," Dr. Beaver opined that Colton "could benefit from a trial of medication." Regarding the issue of attention, Dr. Beaver preferred to "defer to Dr. Adler with regard to psychopharmacological treatment intervention."

Question #4: In light of mother's confirmation of some prenatal alcohol exposure, what is the most likely origin of Colton's neuropsychological profile?

Dr. Beaver stated that "the etiology of his deficits is unclear." Dr. Beaver felt that Colton's neuropsychological test findings did not appear to meet the criteria for a diagnosis falling under the classification of a FASD (Fetal Alcohol Spectrum Disorder). [Paul Connor, Ph.D. reviewed the data and concluded that both by the strict criteria and based on the totality of the case data, the neuropsychological data was consistent with FASD. Dr. Connor's consultative report is attached. Dr. Beaver defers to Dr. Connor's expertise in this area].

Looking at the totality of the neuropsychological profile, Dr. Beaver did not feel that "environmental impoverishment" was "the primary cause of his neurocognitive difficulties."

Question #5: Taken all of the test findings together, what does this mean for his academic planning, remediation, and overall prognosis?

Dr. Beaver opined that Colton would "clearly benefit from more aggressive educational/vocational remediation and intervention."

Dr. Beaver made specific recommendations including (1) extended time for testing, (2) multiple choice as opposed to essay type test formats, (3) structured and enhanced study periods, (4) remediation in Mathematics, (5) Speech and Language Therapy remediation, (6) assistance and/or accommodation in communication, (7) reduced academic course loads, (8) vocational counseling, (8) long-term individual psychotherapy, and (9) positive role-modeling programs.

Dr. Beaver in his report stated that there were features present "that would indicate he has the potential to become a "normal" adult and a contributing member to his community." Dr. Beaver

noted that Colton's overwhelmingly adverse life circumstances, however, had deprived him of an "adequate opportunity in this regard." [The diagnosis of ARND (see below) does color the overall matter and emphasizes the need for optimal structure, guidance and supervision].

MINNESOTA MULTIPHASIC PERSONALITY INVENTORY – 2 (MMPI-2):

The MMPI-2 is the most frequently used psychological tests in both clinical and forensic work. The MMPI-2 is a tool used to assess personality, mental illness and also provides insight into an evaluee's "response style."

The MMPI-2 consists of 567 statements to which the examinee is asked to respond "true" or "false." It is computer-administered and scored.

The use of the MMPI- 2 is that of a "hypothesis generator." Its results are based on actuarial data. Inferences are made by comparing an individual's response pattern, or profile, to similar patterns produced by a large number of other individuals of similar age and gender. Statements or observations about a particular person who has completed the MMPI-2 ought not to be used in isolation and should be compared with additional data in arriving at professional psychiatric opinions (i.e. there is a need for the information relied upon to have "convergent validity").

Colton's test was sent to the internationally-recognized MMPI expert Alex Caldwell, Ph.D. Dr. Caldwell read the MMPI-2 "blinded"- he had no knowledge of Colton, his circumstances, etc. Dr. Caldwell was only provided with demographic data (age, gender, years of school completed). Colton's MMPI-2 profile appears to be both valid and interpretable. Dr. Caldwell advised regarding the need "for an element of caution in the use of his test results," owing to slight inconsistent responding or efforts to "look sick." Further examination of the supplemental scales suggests that the greater part of Colton's elevation on the F (i.e. Distress) scale was probably due to genuine emotional disturbance.

Overall, the profile Colton produced indicates "an acute identity crisis of young adult life." Colton tested as a person who was acting out with poor impulse controls and defective judgment and forethought.

Dr. Caldwell cautioned that experimentation with alcohol and with tension-relieving drugs might have led to serious breakdown of impulses. Colton's results reflect a potential vulnerability to chemical addiction. The long term risk of eventual abuse of and dependence on drugs, alcohol, or other chemical agents was described as significant.

Dr. Caldwell predicted Colton to have sensitivity to anything approximating a personal rebuff. Colton tested as moderately introverted and socially shy. His specific MMPI-2 pattern has been labeled the "chip on the shoulder" or "wounded pride syndrome".

Dr. Caldwell remarked that "[I]n many similar cases temper tantrums were a major way of getting what they wanted as children as well as a way of dealing with parental indifference and limited affection." He identified likely issues of shame about his parents and the family home.

Dr. Caldwell characterized Colton's profile as related to a "...crisis of caring versus cruelty." It is my understanding that what Dr. Caldwell means by this is that Colton's psychological problems result from victimization involving cruelty. Colton received this instead of the caring and nurturance all children need and wish for.

Given the comments above, Dr. Caldwell identified the important role of the family in the treatment of persons with this profile. He stated that "[I]n many similar cases, work with the family to help them to clarify their feelings toward the patient and to plan how manage his behaviors was reported to be of more long term benefit than were the efforts to treat the patient in psychotherapy.... Intensely hurt and angry feelings about his current emotional relationships are a likely focus of treatment."

Dr. Caldwell continued: "...he is apt to be slow to reveal historical details because of his shame about his family and his dislike of being seen as an angry and resentful person. He could make a show of indifference about an unfavorable or disrupted current situation as an outward defensive front and as a maneuver to get out of treatment. He would partly react to the therapist as a parent-surrogate and then test him with negativistic actions."
In analyzing the results, Dr. Caldwell advised that one should consider "...how he [Colton] expected the test results to be used. That is, he appears to have had some concerns lest the results reflect poorly on him or perhaps end up being hurtful to his self-interests."

Dr. Caldwell contrasted the "traditional diagnosis" associated with such as profile (i.e., Paranoid Personality Disorder) with his expert formulation. He termed Colton's profile as one of 'sensitization to unfairness.' This is often seen as an adaptation to a childhood marked by "cold judgments with unduly harsh punishments."

Persons with this profile have often been exposed to "(especially punitive) actions against self and/or others. They can react, showing poor control and poor anticipation of the consequences of their actions, and they do not recognize their own internal conflicts and anxieties. Irritability is apt to lead to temper problems. At more severe levels the person can become litigious or even dangerously retaliatory when he or she believes self (or society) to have been seriously and callously wronged--someone must be stopped from hurting others."

Colton's Neurotic-Psychotic Index was 107, which represents a marked elevation. Dr. Caldwell pointed out that such elevations are associated with idiosyncratic understandings of one's world and misinterpretations of the intentions of others and this could add to potential dangerousness, including not letting anyone in too close emotionally.

Most important of all, is the section in Dr. Caldwell's report addressing the "Contributory Shaping History" of Colton.

In profiles like the one Colton produced:

"...typically the parental expectations or rules were enforced quite literally, without consideration or flexibility regarding the needs and distresses of the child. Parental (or other family members') tempers are apt to have been intensely threatening and frightening to the person as a small child. The parents were experienced as punitive and coercive of the child's will and punishments were often severe."

Dr. Caldwell opined that based on the test results: "The risk of future delinquency and of difficulties with the law appears at least mild to moderate" (i.e. but not severe).

JESNESS INVENTORY – REVISED (JI-R):

The Jesness Inventory–Revised (JI–R) was designed to help caseworkers, psychologists, teachers, youth counselors, and parole and probation staff better understand the nature and differences that define the groups of people with whom they work.
The computerized report produced is an interpretive aid, which should not be used as the sole basis for intervention or clinical diagnosis. The report is best used when combined with other sources of relevant information (e.g., observation, historical information). Clinical skill must be applied to detect interpretive subtleties that may exist for specific cases.

The results of Colton's JI-R are consistent with two profile types: I-3 and I-4. It was hoped that one of the profiles could be elected for presentation over the other. However, both the I-3 and I-4 profile descriptions seem quite apt and excerpts from each are presented below.

The Validity Scale scores reflect that there was little to indicate that Colton was presenting an unrealistically positive image. Also, he appeared to attend to the items in a manner than did not reflect any randomness or carelessness. Thus, the profile was considered to be valid and interpretable.

Colton's T-score for the Social Maladjustment (SM) scale does not indicate a problem. His score on the SM scale suggests that Colton generally disapproves of antisocial behaviors and has attitudes that are quite different from those of delinquent persons.

Value Orientation (VO). Persons scoring high on VO tend to share the attitude of persons who value "toughness," tend to blame failure on bad luck, seek thrills, and are inclined to be gang-oriented. Colton's T-score for the VO scale was not significantly elevated.

The Immaturity (Imm) scale measures the tendency to display attitudes and perceptions of self and others that are most typically held by persons of a younger age. Note that this scale pertains to attitudinal immaturity, not physical immaturity. Colton's maturity level was comparable to other individuals in the same age group.

Autism (Au) score. Individuals scoring high on the Au scale tend to have their thinking unduly regulated by personal needs and are absorbed in self-centered, subjective mental activity. Colton's profile did not include an elevation on the Au scale.

Alienation (AI) score. AI measures the presence of distrust and estrangement in the person's attitudes towards others, especially those representing authority. Colton's T-score did not indicate a problem of alienation.

Manifest Aggression (MA) score measures awareness of feelings of anger and aggression and a tendency to react quickly with emotion. Colton's score does not indicate an awareness of problems with anger or aggression.

Withdrawal-depression (Wd) score measures a tendency to isolate one's self from others and a perceived lack of satisfaction with self and others. Colton's score does not indicate a problem in the area of Withdrawal-depression.

Social Anxiety (SA) score measures perceived emotional discomfort (i.e., tension, anxiety), especially with respect to interpersonal relationships. Colton's score does not indicate a problem with Social Anxiety.

Repression (Rep) refers to an atypical exclusion of feelings or attitudes (especially of hostility) from consciousness. Colton's Rep score does not indicate a problem with repressed thoughts.

Denial (Den) measures an individual's reluctance to accept or acknowledge unpleasant aspects of reality which are found in day-to-day living. Colton's score does not indicate the use of denial as a defense mechanism.

Asocial Index (AI) refers to a generalized predisposition to resolve problems of social and personal adjustment in ways ordinarily regarded as showing disregard for social customs and rules. The Asocial Index and the Social Maladjustment scale are the best measures of delinquency and adult criminal proneness. Colton's scores on neither the Asocial Index nor the Social Maladjustment scale were significantly elevated. Thus, there is no strong evidence of antisocial tendencies.

Conduct Disorder (CD). Individuals with a clinical diagnosis of Conduct Disorder display behavior, which is "repetitive" and "persistent" in four main areas: aggression to people and animals, destruction of property, deceitfulness or theft, and serious violations of rules. Colton's T-score for the CD scale was slightly elevated. However, a T-score in this range is not usually indicative of a major problem with the behaviors associated with Conduct Disorder.

Oppositional Defiant Disorder (ODD): Individuals with a clinical diagnosis of Oppositional Defiant Disorder display a pattern of "negativistic, hostile, and defiant behavior". Colton's T-score for the scale does not indicate a problem with the behaviors associated with Oppositional Defiant Disorder.

Statements related to the I-3 Profile are presented below.

In most applications, such a person is best termed a "Pragmatist". On the restandardized version (JI–R), a similar percentage -- 16.4% of non-delinquents versus 18.4% of delinquents/criminals -- were classified as I-3s.

The following were found to be characteristic of this subtype within *delinquent/offender* samples:

- Early involvement in delinquency,
- When in school, somewhat negative attitude toward teachers, but motivation for school achievement higher than most other subtypes.
- Generally positive attitude about parents. However, a history of conflict with fathers is common, and overprotection and lack of discipline by mothers has allowed them to get what they want most of the time. Mothers of "Pragmatists" tend to be inconsistent, being at times rejecting (even sadistic), and at other times accepting.
- Some distrust of, alienation from, and hostility toward authority, which may not be apparent on the surface.

I-4 Profile Type ((NA) Autonomy-Oriented -- Neurotic, Acting Out):

Colton's profile was also classified as NA. In most applications, a NA is best regarded as or termed "Autonomy-Oriented". However, when dealing with deviant groups, the term "Neurotic, Acting Out" may be more appropriate. On the restandardized version (JI–R), 18.5% of non-delinquents versus 13.2% of delinquents/criminals were classified as NA.

Compared with I-3 types, those at the I-4 level show more evidence of internalized standards by which they judge their own and others' behavior.
Consequently, some individuals of this type may experience guilt over their failure to live up to these standards.

The guilt may be reflected in a rather defiant stance that is a cover-up for an early ("bad me") image of inadequacy or unacceptability. Those at this level show some ability to look for and understand reasons for their behavior. They show some awareness of the effects of their behavior on others and of others' behavior on them. An autonomy-oriented individual's overt stance is usually one of adequacy coupled with an emphatic striving for independence.

Friendships are made on a selective basis. Persons of this subtype often anticipate a parent/child type of relationship wherein others are attempting to control their behavior. Because they expect to be treated in an authoritarian manner, they are prone to test others to determine whether they are supportive persons to whom they can relate. Apparently because of their need to cover up a "bad me" image, they are often reluctant to reveal much of themselves or to allow people to become too emotionally close to them for fear that others might discover how "bad" they are.

When behavior problems occur, they are often related to a family problem or to a long standing internal conflict, particularly involving the internalization of a parental image or authority figure.

The following were found to be characteristic of this subtype within delinquent/criminal samples:

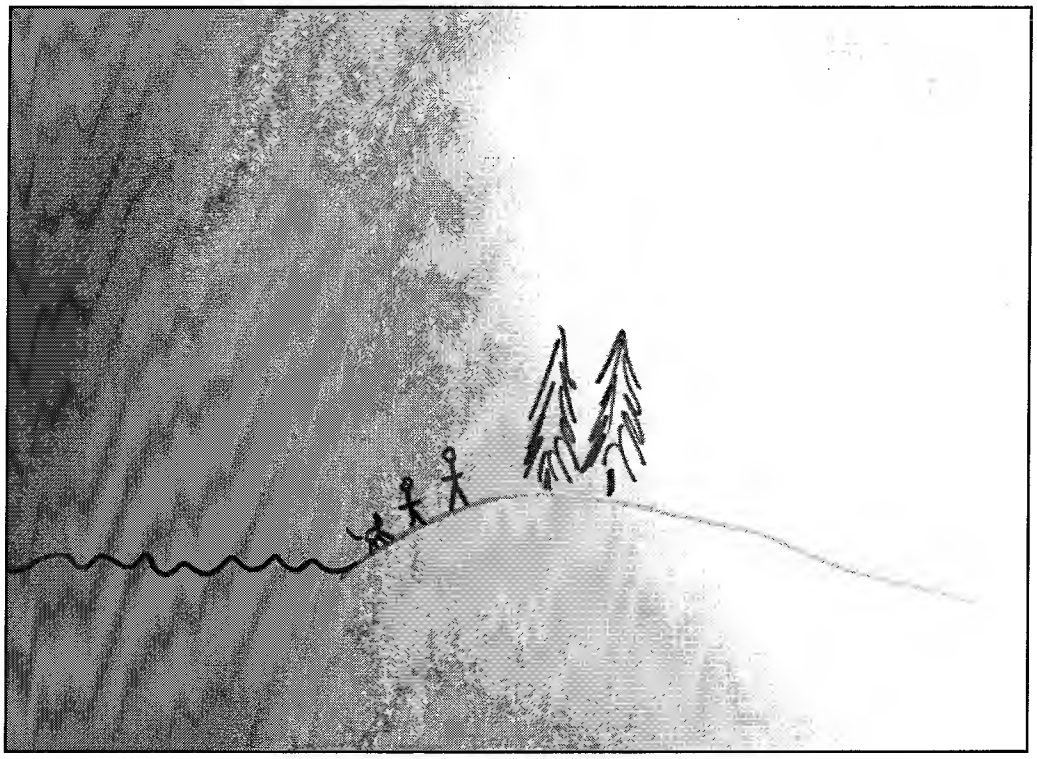
- Background: Typically from average (to above average) socioeconomic home environment; prior patterns of running/escape are not uncommon.
- School/Achievement: Tend to be above other subtypes in intelligence, but often present behavior problems in school (despite generally positive attitude toward teachers).
- Perception of Family: Most likely subtype to express negative feelings regarding family (especially conflict with father); see family as lacking cohesion, mutual trust, and as conflicted and argumentative. Realize they play a part in family problems.

- Self-Concept: Profess being smart and tough, but are disenchanted and not really sure of themselves. May be perceived as "mixed up" (and may also see themselves as mixed-up). Aware of feelings of anger and of being easily upset.
- Authority: Tend to have hang-ups with supervisors/counselors and others in authority; prone to defy and provoke others.
- To work effectively with the NA, it is necessary to gain his or her respect. To be seen in a non-authoritarian role, staff must be willing to admit to errors and personal inadequacies. Counselors should be honest and avoid a front of authoritarian adequacy. They should avoid being hypercritical or fault-finding and be willing to be available for any attempt at interaction. Because the search for autonomy represents a principle drive of the NA personality, the staff member should not be control-oriented and should be willing to allow the client considerable freedom to make choices and decisions.
- The long-term goals of treatment include identifying, reducing, and resolving internal conflicts. The client needs to appreciate and accept limits on behavior, and to try to become more considerate of others. A desirable objective is to moderate the NA's need for defense mechanisms that keep others at a distance. Treatment staff should help clarify the NA's perception of self and to change the self-image away from "bad me" to one of personal worth and acceptability.
- To attain these goals, therapists should work to develop a mutually trusting and reciprocal relationship. Focusing treatment on specific behavior problems may not be helpful. It is usually better to focus on underlying feelings and problems. This approach may, however, produce a negative emotional response from the NA. If so, staff should offer support in such a way as to avoid threatening the individual's self-image of independence. Individual counseling usually works better than group counseling because the NA's self-image of inadequacy prevents him or her from discussing problems freely in front of a group.

KINETIC FAMILY DRAWING:

Colton was provided paper and markers of various colors and asked to draw "your family doing some activity." Colton was cooperative with the task, and asked: 'I guess you want me to use different colors."

His drawing is shown below, reduced in size. Colton explained that it features his dog, him and his mother "at the beach." Colton and his mother are shown as stick figures. Colton is drawn as smaller than his mother. Although Colton appeared to take his time, the drawing is nonetheless rudimentary and "minimalistic" and appears to be representative of something that would be produced by a much younger person.



SUGGESTIBILITY:

At examination of May 24, 2011 I administered the Gudjonsson Suggestibility Scale – 2 (GSS-2).[6]

The GSS addresses the susceptibility of an examinee to endorsing information, particularly in the context of interrogative questioning that features "leading questions" and pressure from authority. The examinee is read a short story containing 40 distinct elements. The examinee is then asked to recall as much of the story as possible. Thus, the maximum score achievable is 40.

Up to 50 minutes later, 20 pointed questions are asked. Fifteen of them are "leading questions." After the first round of questions, the examinee is told that some of his answers are not correct, and the questions are then repeated. It is noted how many times the examinee succumbs to the misleading questions on the first round (i.e. Yield 1) and how many times he changes his answers from the first to the second round (Shift). The sum of Yield 1 and Shift is reported as "Total Suggestibility." Colton cooperated fully with the testing procedure and exhibited reasonable effort as he tried to recall information. His scores are reported below.

GSS-2 DATA

CATEGORY	MAXIMUM POSSIBLE SCORE	TYPICAL 11-12 YEAR OLDS [4]	COLTON'S SCORE	ADULT NORMS [7]
Immediate Recall	40	17.1	12	18.9
Delayed Recall	40	--	5	--
Yield 1	15	4.6	3	3.4
Shift	20	3.4	7	4.0
TOTAL SUGGESTIBILITY	35	8.0	10	7.4

These results indicate that Colton's Immediate Recall was impaired. In addition, his tendency to yield to pressure from authority is twice that of that of normal 11 - 12 year olds, and greater that a comparison group of adults. Findings such as these are consistent with neuropsychological impairment.

[6] Gudjonsson G. The Gudjonsson Suggestibility Scales Manual. Hove, East Sussex, UK: Psychology Press, 1997.
[7] Pollard R, Trowbridge B, Slade PD, et al. Interrogative Suggestibility in a U.S. Context: Some Preliminary Data on Normal and FAS/FAE Subjects. Personality and Individual Differences, 37(5): 1101- 1108, 2003.

DISSOCIATIVE EXPERIENCES SCALE – II (DES - II):

The DES consists of twenty-eight (28) statements to which respondents are asked to endorse the percentage of the time they have the experience described. Each statement is followed by an eleven-point Likert Scale that extends from "Never" (i.e. 0%) to "Always" (i.e. 100%) in 10% increments.

He endorsed only two (2) items, and both at a level of only 10%. The average for the 28 items was 0.71. The General Population scores between 3.7 and 7.8.[8]

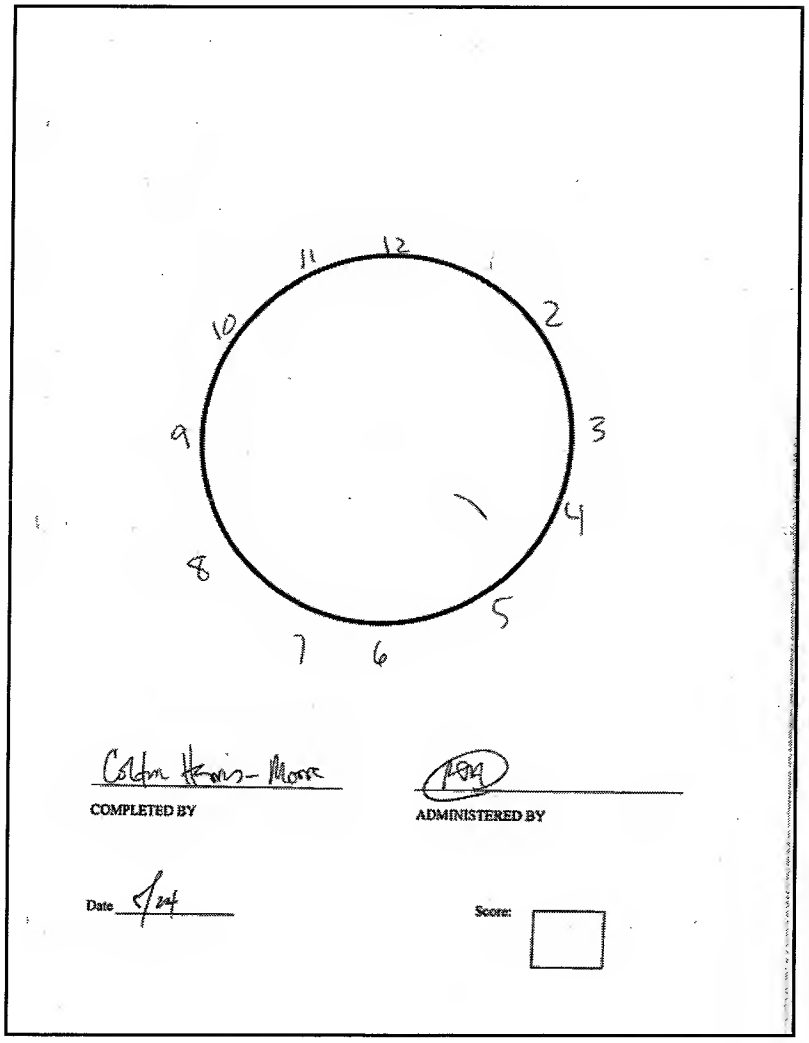
DRAW A CLOCK (DAC) TEST:

The DAC is a neuropsychiatric screening test.[9] It may also be useful as an external indicator of validity/ "response style" (i.e. including possible malingering and/or exaggeration of deficits). An examinee is asked to place the numbers on a sheet of paper that already has a circle on it "like a clock."

Colton's DAC is shown below slightly reduced.

Colton placed the numbers on the outside of the circle, not on the inside. Aside from this, the numbers are well-placed around the circle. [In my experience administering the DAC over 50 times, this was the second time I had ever seen anyone place the numbers on the outside of the circle. The first such response was provided by Colton's mother]. His approach to the DAC may represent elements of impulsivity and impaired executive function negatively impacting on the task. Emotional/psychological issues may also be relevant.

[8] Carlson EB, Putnam FW: "An Update on the Dissociative Experiences Scale," Dissociation 6(1): 16 – 25, 1993.
[9] Shah J. Only Time Will Tell: Clock Drawing As an Early Indicator of Neurological Dysfunction.
P & S Medical Review. Spring 2001, 7(2): 30 – 34.



Colton Harris-Moore
COMPLETED BY

ADMINISTERED BY

Date 5/24

Score:

BEHAVIOR RATING INVENTORY OF EXECUTIVE FUNCTION®–ADULT VERSION (BRIEF®-A), INFORMANT VERSION COMPLETED BY MS. PAM KOHLER REGARDING COLTON HARRIS-MOORE (MAY 30, 2011):

According to the publishers of this test,[10] the BRIEF-A is a standardized measure that captures views of an adult's executive functions or self-regulation in his or her everyday environment. The test is composed of 75 items from which the following scales are derived, reflecting various aspects of executive functioning:

1. Inhibit,
2. Self-Monitor,
3. Plan/Organize,
4. Shift,
5. Initiate,
6. Task Monitor,
7. Emotional Control,
8. Working Memory,
9. Organization of Materials.

The test has demonstrated evidence of reliability, validity, and clinical utility as a sensitive measure of executive functioning in individuals with a range of conditions across a wide age range. I am unaware, however, of its applicability in forensic circumstances.

Interestingly, despite the findings on neuropsychological testing (reported above) and Ms. Kohler's prior request to have Colton undergo a brain scan, the only scale with a clinically significant elevation (i.e., one that reflects a problem) was the Self-Monitor scale.

PRIOR EVALUATION, DELTON YOUNG, PH.D., JUNE 15, 2007:

The evaluation was done at the request of defense counsel. Colton was evaluated in the Island County Juvenile Detention facility in Coupeville, WA. His mother was interviewed by phone.

Colton had been arrested on February 10, 2007 and was facing 23 criminal charges, the majority of which were for possession of stolen property.
He was to go to trial in Juvenile Court in August 2006, but fearful of incarceration, he told Dr. Young: "I took off before the day of the trial." He was in hiding for six months, staying with friends he met while on the run. It was during the six months in hiding that he accumulated the 23 criminal charges referenced above.

[10] http://www4.parinc.com/Products/Product.aspx?ProductID=BRIEF-A, accessed September 13, 2011

Interview of Colton's mother by Dr. Young produced an account of a generally normal early development but for Colton's tendency to "beat his head on the wall when he was a toddler." Colton's father (Mr. Gordon Moore) was in and out of the home until he was five, but was then in prison for several years thereafter. Dr. Young stated that from his review of the records the father at some point told Colton "that he had killed three people," but that this had not been verified. (Young at p.3, paragraph 1).

Colton reports that he felt a close relationship with his mother when he was a young child, up to five or six years of age. He also reported that he had enjoyed a very positive relationship with Aunt Sandy "until my morn alienated them." Colton explains that when he was 10 or 11, it became clear to him the extent and the damage of his mother's alcoholism. He reported that on one occasion he tried to give her a Bible and on another occasion an AA book, but "she burned it." He reports that when his mother is drinking, she is "mean" and "she will break my things...she yells and screams at me," Colton stated that when he was 11 or 12, she became increasingly angry, and she seemed to care less and less about his attending school and functioning as a student. He stated that she never did help him with his schooling.

When Colton was four years old, a citizen reported to CPS that "he saw a woman grab a small child by the hair and beat his head severely."

Another referral, in May of 2003, indicates that Colton's father, Gordon Moore, assaulted him. The referrer indicated that the father was then taken away on outstanding warrants by the police: "Child alleges Gordon threw him into some nettles and held him down by the throat... Child alleges Gordon stated 'don't you know, I have killed three men because of my anger," which the child took as a threat... His mom was drunk and screaming at him and after the police left, she stumbled around asking "what are you going to do now? They have taken your father away" Colton was "quite attached" to his stepfather, Mr. Kohler, even though he was not a person who Colton could "count on."

In the home at the time of the evaluation was a man named Van Jacobson who resided in the home "on and off" during the prior several years. Colton has a maternal half-brother, Paul (36) who was living in Granite Falls with his two children. Colton had not seen his brother for at least two years, and he reported that his mother and Paul had no contact for several years. There are no other siblings.

He also has been prescribed a wide range of psychiatric medications including antidepressants, stimulant medications, mood stabilizers, and even an anti-psychotic medication.

Colton last attended school regularly at the Lincoln Hill Alternative School in Stanwood from the middle of the 2005-2006 school year. He reported, however that he was absent much of the time. He stated that he was home sleeping, and that his mother did not make much effort to get

him to attend school. Prior to being transferred into the Lincoln Hill Alternative School, he had attended Stanwood Middle School for the previous two and a half years. While at Stanwood Middle School, he accumulated numerous incident reports most of which were for truancy, between 2002 and 2005. The incident reports also included a theft, vandalism, and three incidents of harassment/bullying. Most of these incidents resulted in in-school suspension (ISS). However, he also was expelled on one occasion.

Dr. Young's assessment of 5/21/2007 included six subtests of the Wechsler Intelligence Scale for Children - Fourth Edition (WISC-IV).[11]

The results were:

SUBTEST	SCALED SCORE	PERCENTILE	STANDARD OR SUBSTITUTE
Similarities	10	50	Standard
Digit Span	9	37	Standard
Vocabulary	9	37	Standard
Matrix Reasoning	9	37	Standard
Information	9	37	Substitute
Arithmetic	9	37	Substitute

Of note, nine (9) subtests were not performed. As a result, only the Verbal Comprehension Index (VCI) could be calculated with Dr. Young's results; the VCI = 98 (45th percentile).

Colton generated a valid Millon Adolescent Clinical Inventory (MACI) with high self-revealing inclinations and some self-deprecating response tendencies. The clinical profile suggested an adolescent with depressive, fearful, and socially anxious attributes. He appeared to have feelings of self-reproach and guilt; his profile was that of a teen who would often appear somber.

Colton's profile suggested that he felt deep resentment toward those upon whom he must lean because he feels that they are inconsiderate and critical. Because his security may be threatened when resentments are expressed, he may tend to discharge them in a passive-aggressive or self-defeating manner. Feelings of inadequacy and emotional dysphoria are usually present with mixes of mournfulness, dejection and guilt. *He appeared to suffer a persistent, chronic state of depression.*

Dr. Young indicated that Colton recalled having been victimized by adults throughout most of his childhood. Remembering incidents in which he was abused, he feels a degree of anger and

[11] Some of the tests performed are part of the standard battery often used in calculating full-scale IQ (FSIQ); others can be substituted for the standard subtests.

confusion. He is likely to show quick and impulsive reactions with inadequate thought given to the consequences of his behaviors. There may be an ever increasing spiral of difficulty within family settings, dysthymia (depression is an integral part of this adolescent's current life). He likely has feelings of uselessness, dejection, pessimism, discouragement, and pervasive self-doubts.

Persons with a profile like Colton's will describe life as meaningless and empty. He described serious problems in the family and lack of support. Such difficulties may reflect either severe parental rejection or possibly a sharp break on the part of this adolescent as he asserts his independence.

Dr. Young noted that "several aspects of Colton's personal functioning make it clear, however, that he is not a typical antisocial youth…He is best understood through his psychiatric attributes – as depressed and resentful, hopeless and self-defeating."

Insightfully, Dr. Young commented that: "Given the destructive habits we have seen, of course, he would benefit from close supervision, perhaps electronic home monitoring."

Regarding disposition, the evaluator stated that "Colton surely cannot be expected to stay on a positive course living in his mother's home." He felt that Colton's maternal aunt, Sandy Putnam, could provide an appropriate home.

As part of the "Diagnostic Formulation," Dr. Young opined [with some inexactitude] that: "Colton came into the world as a healthy infant and toddler. Unfortunately, he was born into a home situation marked by instability, loss and alcohol abuse…Colton's home and family life precluded the development of basic trust and psychological health in the child. By Colton's account (and that of numerous available records) Colton's mother has been heavily affected by alcohol abuse throughout Colton's developmental years; and there has been a variety of men in the home - boyfriends and husbands who had their own alcohol and drug addictions…
Colton is an intellectually capable adolescent boy who surely would be able to succeed in academic and occupational endeavors in the years ahead given regular attendance and the emotional stability to sustain attention and follow through. For several years now, his ability to apply himself to his schoolwork--indeed even to care about it--has been severely lacking, and he has missed approximately half of his school days in the Stanwood Middle School and in high school. Despite good intelligence, Colton has been unable to sustain the motivation, interest, and focus in schoolwork and other endeavors due to what is now a long-term, agitated and self-defeating depression."

Referrer reports the child disclosed 'mom blamed him for dad going to jail.' In other paperwork related to the previous incident, it was explained that Colton had told the counselor about the bruising and abrasions on his throat. He stated that both of his parents were intoxicated and that

his mother "verbally abused Colton throughout and after the incident... It was also explained that Colton is the one who called 911... His father ran into the woods to escape from the police, but they soon caught him. He was arrested and taken to jail. Ms. Kohler harangued and verbally abused the officers during the arrest... Colton was afraid to go home today."

By the time Colton was 12 to 13 years of age, CPS records reflect an increasingly troubled child with oppositional behavior and even aggressiveness. Records also indicate in several places the mother's unwillingness to engage in chemical dependency treatment as recommended by DSHS. By that time, Colton had begun engaging in vandalism and petty crime. In June of 2003, a social worker contacted Ms. Kohler and concluded "mother is interested in services, but sounds like it will be difficult to get her to really participate...she does not want Compass therapy." In August of that year, the social worker related: "Social worker has concerns regarding this child due to mother's possible use of drugs or alcohol; this judgment due to the men and their habits that have been in Colton's life."

By early 2004, the child is reported to have "constant meltdowns pretty much every day." By July of 2004, when Colton was 13 years aid, the social worker indicates: "Concern is registered that mother seems to be quite secretive in terms of allowing people to know what is going on at the home, and it is noted that she is very inconsistent in following through with more than the initial intake process...Mother did not follow through with engaging in any services offered. Child is seen by island County Juvenile Court worker." By 2005, CPS referral indicates "heard from Uncle Bill that Colton is being abusive to the mom and the house is a mess. Colton is out of control and he has been stealing items. Colton is on probation for a theft...he was recently out of JRA (Echo Glen) and was back in detention last week."

As indicated in records and his own report, Colton began getting in to petty behavior difficulties at the age of 10 in the Stanwood School District; and by the time he was 12 he had engaged in theft and vandalism. He was committed to Echo Glen, JRA; from March 7, 2005 to April 20th of that year for crimes of Theft 2 and Theft 3. From 2002 to 2004, he accumulated numerous incident reports at the Stanwood Middle School most of which are for truancy; but some of which were for harassment/bullying, and there also was a referral for vandalism and one for "theft/accumulation of violations."

At that time, when asked about CPS referrals, Colton's mother, Ms. Kohler, stated that she was unaware of any CPS referrals or investigations.

Colton reported that by 6th grade in Stanwood Middle School, his school attendance had fallen off considerably, and he had no motivation or interest in school. He reported that his mother did not respond in any substantial way to his truancy and said to him "it's your fault, not mine." Of course his grades were very low and he became increasingly behind in school. As a result,

school became harder. Colton estimates that from 6th to 8th grades in Stanwood Middle School, he missed at least half of the time.

Colton reported that his mother was frequently violent to him over the years, but Van was only physically violent on two occasions. He reports that he has a scar on his leg from where she threw a coffee mug at him that broke and cut into his leg. He reports that his mother was violent to him "100's of times." He reported that his mother has been on two-week alcohol binges during which time she breaks things. He reported that in June of 2006, she told Colton that she wished he would die (Young report at page 5). He states that his mother has never been arrested or in any substantial trouble with authorities or the law over her mistreatment or her alcoholism.

Colton was assessed and treated at Compass Health from 2001 to 2004. Colton explained that he never told the clinicians at Compass Health the extent of the physical and verbal abuse by his mother at home for fear that he would be taken away from her and placed somewhere else. At his initial intake assessment in August of 2001, he was diagnosed with ADHD, Parent-Child Relational Problem, and possible Depression. Clinicians indicated sleep disturbance, irritability, and signs of depression. It was also confirmed in the Compass records that Colton had been placed in foster care briefly at the age of 10 following police intervention. Records indicate, by 10 or 11 years of age, that there was increasing oppositionality, but also depression and he was treated with antidepressant medications.

On September 10, 2001, clinicians wrote: "Assertive, talkative 10-year-old who can become quite angry--but the situation with mother and her boyfriend drinking, living in a tiny trailer, mother drinking all the time, and the physical abuse Colton has gotten from boyfriend makes his anger easy to understand. He has gotten into only a few problems at school and is determined to not get into trouble this year." He was treated with antidepressant medications, but subsequently in December of 2001, he was also placed on the anti-psychotic medication, Geodon. Records are not clear as to why such a potent medicine was tried, but most likely it was to assist in behavioral control. He was diagnosed with Intermittent Explosive Disorder, Depressive Disorder, NOS and Parent-Child Relational Problem in 2003. At that time, clinicians quote Colton saying that 'She is in denial about her drinking.' Medical notes indicate "Parent states her drinking helps her deal with Colton and helps her stand up to him."

Colton endorsed many symptoms of depression at that time (2003) such as an inability to sleep for the past three years, and he stated "I am not happy, I am depressed. I could stay in bed all day. I need help. I am tired of this stuff," Clinicians go on to indicate that "There is a 'parent-child relational problem due to the level of conflict between mom and child. This conflict seems largely due to mom's drinking of alcohol.'" The theme of conflict over the mother's drinking is continued in the notes: "Colton wants mom to stop drinking and smoking, get a job, and have food in the house, mom refuses. Many inappropriate father figures in the home over the time, exposing Colton to domestic violence and drug and alcohol addiction/selling." Colton was

eventually tried on the antidepressant medication, Strattera, which was apparently beneficial in alleviating symptoms of depression, as well as agitation and irritability (Prozac had worsened the agitation). In July of 2004, records documented positive response to Strattera. However, under the heading "current status/risk factors: 'Colton's mother did not follow through with recommended substance abuse screening or counseling services, did not participate in parenting classes, and denied having a drinking problem, despite Colton's continued reports of mom's drinking episodes. Colton's mother has not been helpful in getting him to activities or programs available in their community nor has been helpful in assisting him with school success.'" For reasons that are not clear, the Strattera was not renewed at some point, and Colton does not know why. As a result, the one medication that was clearly beneficial was not applied over the past two years.

Colton's account to the examiner of the challenges, misbehaviors, and difficulties over recent years is consistent with those processes and incidents documented in the records, for example, in the CPS and Compass records. Colton was not defensive and he readily acknowledged the numerous episodes of misbehavior on his part including truancy, theft, vandalism at his school, and the criminal charges that he accumulated last year. He does note that he never made any money from his transgressions over the past year.

Dr. Young noted that Colton: "… appeared to be of at least average intellectual abilities." Colton told Dr. Young that, "… his mood drops precipitously after he has a telephone call from his mother. He fears that his mother wants him to get a long sentence."

He reports that for many years he had felt depressed when he was around home and his mother, and his depressed feelings involves dysphoria, lethargy, a lack of motivation, and hopefulness. He also found himself irritable and angry more often when he is at home.
He stated that he had experienced some passive suicidal ideation, for example, thinking "It is scary how easy it would be to die…but I don't want to."

He stated that when he is at home with his mother, he feels depressed most of the time, and indeed, records indicate that he has suffered a depressive disorder for many years. Colton also acknowledges feeling a cranky or irritable mood most of the time not only here, but when he is home with his mother. He did not feel cranky and irritable during the six months when he was on runaway.

Colton stated that he does find that his thoughts race ahead somewhat fast at times and "I feel like my brain is flooded with so many thoughts." On inquiry, however, this does not appear to represent the racing thoughts associated with mania, but rather just states of anxiety. There was no real euphoria as in manic states and there were no special powers, grandiosity, or periods of especially high energy with goal-directed activity.

Colton does not suffer nightmares currently, although he has in the past. He states that he is not particularly plagued by painful memories. On inquiry, however, he does have some painful or intrusive memories of his mother being angry at him and "yelling and screaming" in the car. Not surprisingly, he suffers significant anxiety being in detention and worrying about how long he will be incarcerated. He also noted that he occasionally had brief anxiety attacks when he was on runaway and staying with friends on Camano Island, "because I knew I would get caught." There are no indications of obsessionality and only some mild anxieties about germs and contamination; but these do not rise to a level of obsession or compulsive traits. He is somewhat superstitious, but not overwhelmingly so. His primary worry in life is "my future."

He did report some social anxiety, and there have been times when he would refuse to go out because he feels so self-conscious and embarrassed. This most likely represents the normal range self-consciousness of adolescents.

DIAGNOSIS:

Axis I:	Cognitive Disorder, NOS (DSM-IV-TR Diagnosis Code 294.9) (Due to a General Medical Condition – Alcohol Related Neurodevelopmental Disorder). Depressive Disorder, Not Otherwise Specified (311) Posttraumatic Stress Disorder, In Remission (309.81) Parent-Child Relational Problem (V61.20) Physical Abuse of Child (Focus of Attention is on Victim) (995.54) Mathematics Disorder (315.1) Expressive Language Disorder (315.31) Rule out Cocaine Abuse, In Remission, In a Controlled Environment (305.60)
Axis II:	Adult Child of an Alcoholic (ACOA)
Axis III:	Alcohol-related Neurodevelopmental Disorder (ARND) (Provisional) Elevated thyroid function test (8/8/2001) – T3 TOTAL = 208 (normal 60 – 181 ng/dl) apparently unaddressed in later medical records
Axis IV:	Stressors: Severe (Childhood poverty, Parental alcoholism, Sudden death of stepfather, possibly due to drug overdose, Incarceration, Facing Serious Federal, State and Other Charges).
Axis V:	Global Assessment of Functioning: 55/100 maximum currently, 55/100 prior year (estimated)

OVERALL SUMMARY:

This psychiatric evaluation represents the most thorough and comprehensive that has been conducted on Colton to date.

The main goals for a psychiatric evaluation addressing mitigation and sentencing/disposition are to:

(1) offer explanatory information related to the subject offense(s),
(2) identify any relevant risk factors for recidivism, and
(3) provide recommendations to minimize and/or eliminate these recidivism-related risk factors.

It should be appreciated that in any wide-ranging evaluation there is likely to be discrepant and/or contradictory information between records, test findings the various informants. That was true in this evaluation, but to an even greater extent than usual. Dates, chronologies and details provided were often inexact. Ms. Kohler appeared to have a defensive and self-protective reporting style, best reflected in her stated concern that the purpose of my interviewing her was "to make it out to be all my fault."

Ms. Kohler's responses on the BRIEF reflects the overall impression I had of her reporting style – namely that she was "out of touch" with her son's difficulties. Her confusing posture was that Colton has 'something wrong with his brain,' coexisting with minimization. Her inability to accurately report on his deficits likely contributed to her ineffectiveness in advocating for him when he was younger.

In contrast, Colton's statements were very often forthcoming, accurate and borne out by testing and the records reviewed.

Colton told Dr. Beaver about the instruction he received at home to *avoid being open and forthcoming* with helping professionals. This was corroborated for me in the process of piecing together the course of events surrounding Colton's stepfather's sudden, traumatic and suspicious death while passing through Oklahoma.

Autopsy records reveal that Mr. William Kohler died on August 17, 2002. At a pediatric visit on September 4, 2002, behavioral problems were reported by his mother. No mention was made of the stepfather's sudden death. When asked specifically about this, Ms. Kohler told me that she felt no need to share these kinds of details. Colton reported to me that immediately following his stepfather's death his mother 'went on a binge for a month and broke every dish in the house.'

Insight into Ms. Kohler's poor control over her emotions and her propensity for abusive rage were gleaned from a digital recording of the thirteen (13) voicemail messages left for the defense mitigation specialist (Ms. Pamela Rogers) over less than a day in August 2011. Ms. Rogers had failed to return materials to Ms. Kohler in the time frame promised.

Clearly, the defense mitigation specialist is employed to *assist* Ms. Kohler's son.

Ms. Kohler's comments to Ms. Rogers included:

- "You are going down, broad,"
- "I'll destroy your ass!"
- Now! I'll come looking for you and you will not be happy when you see me."

Ms. Kohler's rageful behavior is consistent with extended family reports and the official records reviewed.

Colton, on the other hand, appeared to be become more forthcoming and open over time, in particular:

- comparing interview #1 and interview #2 that I conducted with him,
- over the course of interview #2 that I conducted with him and,
- between interviewers (i.e. this examiner, the mitigation specialist and the neuropsychologist, Dr. Beaver).

This tendency to open up and become more forthcoming in interview #2 was noted by Alex Caldwell, Ph.D. in his "blind reading" of Colton's MMPI-2.

Colton's willingness to be forthcoming is especially remarkable in the face of the many inconsistent and hurtful adult caregivers in his early life.

It is particularly remarkable given the numerous times in his life that he did disclose problems at home, but for which no meaningful intervention resulted.

Colton made disclosures that may not be clearly in his self-interest *prior to the final disposition of serious Federal and State charges*. This lack of guile is consistent with the MMPI-2 and JI-R findings which indicate he does not have Antisocial Personality Disorder.

Colton's prevailing "good nature" is best demonstrated in the fact that although he: (1) had a childhood history of being abused and neglected, (2) has neurocognitive impairments, (3) has a history of anxiety symptoms and Posttraumatic Stress Disorder after piloting his first plane, (4)

was in possession of a gun, and (5) shots were being fired in his direction in the Bahamas – there is no clear indication that Colton ever fired a gun at anyone.

Lamentably, "hindsight is 20/20." The course of events might have been significantly different if prior evaluations had adequately identified and intervened in Colton's various neurocognitive and social problems.

As supported by the professional literature[12] language impairments in young children are an indicator of significant overall developmental vulnerability. Such children show

> "...clear long-term deficits in language, cognitive and academic domains relative to peers without early language difficulties" (at page 755).

As was present in Colton's case, there is a tendency for such children's problems to either go unaddressed or to be addressed inadequately.

It is nothing less than tragic that the school system's response to Colton's deteriorating academic performance was to simply assign in-school detention for late arrivals.

The Johnson et al study notes that persons with language-based LDs, (all etiologies taken together), may "pursue occupations requiring less education," implying that they do become actively employed and are productive despite having such conditions.

Additionally encouraging is the finding that such persons "are equally satisfied with their overall quality of life" (at page 756).

There is both first-hand and collateral confirmation regarding prenatal exposure to alcohol and cigarette smoking during the pregnancy with Colton – both of which are harmful.

It is not uncommon for women to drink prior to becoming aware of a pregnancy. The first trimester appears to be a time of particular risk for harm from prenatal exposure.

The kind of drinking reported by Ms. Kohler initially in the interview is highly consistent with serious harm to the fetus[13]. Ms. Kohler's *later* characterization of her drinking, while decidedly

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[12] Johnson CJ, Beitchman JH, Young A, et al. Fourteen-Year Follow-UP of Children With and Without Speech/Language Impairments: Speech/Language Stability and Outcomes. J Speech, Language and Hearing Research. 42: 744 – 760, 1999.

[13] Barr HM, Streissguth AP. Identifying Maternal Self-Reported Alcohol Use Associated with Fetal Alcohol Spectrum Disorders. Alcoholism: Clinical and Experimental Research. 25(2): 283 – 287, 2001.

less extensive still represents the occurrence of a "binge" in the first trimester. Such drinking can be harmful.

Binges are 3 – 5 drinks ingested within a short period of time. They produce an elevated blood level in the mother, and a similarly elevated level in the fetus via osmosis through the placenta.

Binges are considered especially harmful to the developing fetus. In contrast to the mother, the fetus at this stage of development lacks a functioning liver and cannot effectively metabolize alcohol. This results in the fetus' longer exposure to toxic levels of alcohol. The U.S. Surgeon General's office in its second public warning regarding prenatal alcohol exposure (2005)[14] stated:

> "We do not know what, if any, amount of alcohol is safe. But we do know that the risk of a baby being born with any of the fetal alcohol spectrum disorders increases with the amount of alcohol a pregnant woman drinks, as does the likely severity of the condition. And when a pregnant woman drinks alcohol, so does her baby. Therefore, it's in the child's best interest for a pregnant woman to simply not drink alcohol…
>
> In addition, studies indicate that a baby could be affected by alcohol consumption within the earliest weeks after conception, even before a woman knows that she is pregnant. For that reason, the Surgeon General is recommending that women who may become pregnant also abstain from alcohol."

FASDExperts has developed a proposed model standard for the forensic diagnosis of Fetal Alcohol Spectrum Disorders.[15] In our journal article we describe what are more stringent diagnostic criteria than those identified by either the Institute of Medicine (1996) and the Centers for Disease Control (2004).

I was hampered in my evaluation of Colton due to the Federal Detention Center staff's repeated refusal to permit me to perform a physical examination of Colton – which is part of our published protocol and widely-recognized guidelines. Mere evaluation of facial

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[14] http://www.surgeongeneral.gov/pressreleases/sg02222005.html, accessed September 2, 2011 and attached.
[15] Brown NB, Wartnik AP, Connor PD, Adler RS. A Proposed Model for Forensic Assessment of Fetal Alcohol Spectrum Disorders. J Psychiatry and the Law. 38(2): 383 – 418, 2010.

features is inadequate. A physical examination is important in performing a suitable evaluation for FASDs.[16]

Under the circumstances I have made a provisional diagnosis of a Fetal Alcohol Spectrum Disorder (FASD), namely Alcohol Related Neurodevelopmental Disorder (ARND). This is based on the presence of confirmed prenatal alcohol exposure and the characteristic pattern of neurocognitive deficits as articulated by the Centers for Disease Control in 2004. Dr. Connor indicated in an email that the neuropsychological deficits associated with FASD are present. Dr. Beaver and I concur that Colton's diagnosis of Cognitive Disorder, Not Otherwise Specified is most likely the result of prenatal alcohol - compounded by cigarette exposure.[17]

This conclusion is further supported by examination of a chronology of Colton's life history. Colton was born less developmentally mature than would be expected given the length of the pregnancy and he was shorter and weighed far less than what would be expected. This is seen in in infants prenatally exposed to alcohol.

Likewise, his life course of neurobehavioral problems is consistent with the well-described trajectory of persons adversely affected by prenatal exposure to alcohol.[18,19,20,21,22,23,24]

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[16] Jones KL, Hoyme HE, Robinson LK et al. Fetal alcohol spectrum disorders: Extending the range of structural defects. Am J Med Genet Part A 152A: 2731 – 2735, 2010.

[17] Rivkin MJ, Davis PE, Lemaster JL, et al. Volumetric MRI Study of Brain in Children With Intrauterine Exposure to Cocaine, Alcohol, Tobacco, and Marijuana. Pediatrics.121(4): 741 – 750.*Pediatrics* 2008

[18] Streissguth, A.P., Barr, H.M., Bookstein, F.L., & Sampson, P.D. (1999). The long-term consequences of prenatal alcohol exposure: A 14 year study. *Psychological Science, 10,* 186-190.

[19] [2]Carmichael Olson, H., Streissguth, A.P., Barr, H.M., Bookstein, F.L. & Thiede, K. (1997). Association of prenatal alcohol exposure with behavioral and learning problems in early adolescence. *Journal of the American Academy of Child and Adolescent Psychiatry, 36,* 1187-1194.

[20] Mattson, S.N., Riley, E.P., Gramling, L., Delis, D.C., Lyons Jones, K. (1997). Heavy prenatal alcohol exposure with or without physical features of fetal alcohol syndrome leads to IQ deficits. *The Journal of Pediatrics, 131,718-*721.

[21] Noland, J.S., Singer, L.T., Arendt, R.E., Minnes, S., Short, E.J. & Bearer, C.F. (2003). Executive functioning in preschool-age children prenatally exposed to alcohol, cocaine, and marijuana. *Alcoholism: Clinical and Experimental Research, 27,* 647-656.

[22] Schoenfeld, A.M., Mattson, S.N., & Riley, E.P. (2005). Moral maturity and delinquency after prenatal alcohol exposure. *Journal of Studies on Alcohol, 66,* 545-554.

[23] Disney, E.R., Iacono, W., McGue, M., Tully, E., & Legrand, L. (2008). Strengthening the case: prenatal alcohol exposure is associated with increased risk for conduct disorder. *Pediatrics, 122,* 1125-1230. doi:10.1542/peds.2008-1380.

[24] McGee, C.L., Fryer, S.L., Bjorkquist, O.A., Mattson, S.N., & Riley, E.P. (2008). Deficits in social problem solving in adolescents with prenatal exposure to alcohol. *The American Journal of Drug and Alcohol Abuse, 34,* 423-431.

Putting the issue of prenatal alcohol exposure to the side, there have been undeniable and tragic social circumstances in Colton's life.

An important study[25] followed the development of children who mothers were described as being "at psychosocial risk." Such mothers had one or more of the following:

- mental health problems or mental retardation,
- single and pregnant,
- children from four or more different men,
- having seven or more children,
- receiving disability payments,
- prior placement of children in foster care,
- both the woman and partner unemployed for more than a year,
- reported alcohol/drug problems.

Boys of mothers with alcohol and/or drug problems were the most negatively affected among all of the risk factors studied.

Impairments of the mother-infant interaction were observed in this group and were associated with a twenty-fold increase in overall developmental delay by age four.

Not surprisingly, youngsters born to mothers at psychosocial risk experienced more in the way of harmful life events (e.g. death, illness, injury, and parental unemployment).

The boys showed increases in attention problems, aggressive behavior, had significantly worse self-esteem, more commonly failed Mathematics and Language-related courses, and were nearly three times as likely not to complete the 9th grade.

Nonetheless, this group of boys did not have an increased rate of illicit drug or alcohol use.

When asked about it, these boys did not endorse an increased level of dissatisfaction with family functioning (!). The researchers hypothesized that the children "do not disclose circumstances that might be compromising for the mother or the family" out of a sense of 'loyalty.'

Interestingly, the boys studied had a four to five times increased rate of having been placed in foster care. The authors stated: "The children of mothers at psychosocial risk are obviously more often in need of care and protection by the social authorities." Colton did not receive effective care or protection from CPS.

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[25] Wadsby M, Svedin CG, Sydsjo G. Children of mothers at psychosocial risk growing up: A follow up at the age of 16. Journal of Adolescence. 30: 147, 164, 2007.

The researchers also noted that:

> "[T]he absence/reduced frequency of contact with the fathers and thereby lack of male role models together with in many cases weak, psychologically and socially exposed mothers probably contributed to the boys' problems." (At 159)

One of the study's findings is in contrast with Colton's situation; the mothers in the study were found to be accurate reporters of their children's mental health. It is not unreasonable to consider that the accuracy in the mothers' reporting reflects some measure of emotional attunement. Such attunement and connection might have positively impacted these children's satisfaction with their family setting.

In Colton's case, a lack of attunement and connection might have increased his propensity to leave home.

Furthermore, Ms. Kohler publicly stated that she was proud of her son for flying stolen planes. She knew that he had no formal training to do so, and had crashed planes more than once. Her approach to the situation was to advise him to be selective about the type of planes he stole and to carry a parachute (!).

Given the subject crimes, particularly the stealing and flying of planes, there is a nagging question: "is all of this consistent with the neuropsychological, psychological and social history obtained?"

On this point, this examiner, and the consulting neuropsychologists all concur – the answer is yes.

First, persons with disorders in the Fetal Alcohol Spectrum appear "brighter and more alert than tests show." This, in fact, is an item on the "Personal Behavior Checklist" from which the Fetal Alcohol Behavior Scale is derived. [26] This phenomenon often works to the long-term detriment of those with FASD in that the real nature of the person's deficits is not accurately perceived. As a result, they often miss out on much-needed interventions that can be protective for the development of what Streissguth refers to as "secondary disabilities."

Second, although Colton, like 80 – 90% of persons with FASD, has attentional problems – it must be understood that attention isn't an "all or nothing" phenomenon.

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[26] Streissguth AP, Bookstein FL, Barr HM et al. A Fetal Alcohol Behavior Scale. Alcoholism: Clinical and Experimental Research. 22(2) 325 – 333, 1998.

Colton's attentional problems, studied in detail during this evaluation, are evidenced in large part as impulsivity in starting a task and not appreciating the full complexity or nuances involved. A simple demonstration of this can be found in his response to the Draw a Clock Test. On longer, more involved tests which examine "Executive Functions," Dr. Beaver noted that Colton had the ability to detect his impulsive errors made at the start and effectively "self-correct."

Furthermore, attention in general is improved on tasks that are interesting, fast-paced, novel, and have more immediate and relevant rewards and/or danger. Flying a plane is a good example of a task, particularly for Colton, that would have such attributes.

A review of Colton's school records reflects that from early on he was noted to have an ability to plan/organize tasks. This is consistent with the "journal" pages I reviewed. This is a particular cognitive strength for Colton.

Our group, FASDExperts (www.FASDExperts.com), has compiled a "Screening Questionnaire" for use by lawyers, investigators and mitigation specialists. This questionnaire helps identify persons who may have FASD. It is readily available on our website. It consists of thirty-four items listed under five categories.

Of the thirty-four items, twenty-four of them pertain to Colton, the subject crimes and his life history:

1. Illogical actions with high detection risk,
2. "Simple" plan (focus is only on the objective),
3. More sophisticated co-defendants [earlier crimes],
4. Brags about prowess or takes full responsibility if co-defendants [possibly],
5. Unstable lifestyle,
6. Immature and naïve,
7. Eager to please,
8. Can't concentrate,
9. Easily led by more sophisticated peers [possibly in earlier crimes],
10. Multiple low-grade offenses in teen years, often with co-defendants,
11. Lots of stealing,
12. Illogical offenses (e.g., stealing something with little value) [equivocal item],
13. Oblivious to risk,
14. Impulsive, opportunistic crimes [early on],
15. Probation violations,
16. Mom abuses alcohol/drugs,
17. Involvement with child welfare,

18. Adoption/foster or relative placements/juvenile commitment,
19. Special education/learning disabilities in school,
20. Multiple diagnoses in childhood (especially ADDH/ADHD),
21. Rule-breaking behavior (lies, cheats, steals, fights),
22. Disrupted education,
23. Substance abuse [per Colton's report to Dr. Beaver],
24. Unstable adult lifestyle (improves with structure).

Thus, it is not uncommon to see FASD in someone with a presentation like Colton's.

RISK FOR RECIDIVISM:

A 2011 study by Langevin and Curnow provides an in-depth and thorough examination of risk factors for criminal recidivism. It was based on a study population of nearly 1,700 men.

Despite the article's title, an important aspect of the study was its focus on general recidivism[27]. Colton has never been charged with committing any violent crime. This study specifically did not focus on violent crime and/or risk factors for violence.

Langevin and Curnow utilized a variety of measures, including the Psychopathology Checklist – Revised (PCL-R). The rationale for using the PCL-R was to evaluate the various criticisms of this instrument. A common concern is that the PCL-R tests for something (i.e., Psychopathy) that in actuality might only be a measure of persistent criminality.

[In this evaluation the MMPI-2 and Jesness Inventory – Revised were used as measures of antisocial attitudes. It should be stated again explicitly that Colton's test results did not reflect criminal drives or attitudes].

The four most relevant factors for risk of recidivism are identified below:

- Learning Disorder,
- Total Education,
- History of being rendered unconscious,
- Diagnosis of ADHD.

[27] Langevin R, Curnoe S. Psychopathy, ADHD, and Brain Dysfunction as Predictors of Lifetime Recidivism Among Sex Offenders. International Journal of Offender Therapy and Comparative Criminology 55(1): 5-26, 2011.

The authors emphasized the role of "language-based LD," which was common in the group studied. They proposed that the negative impact of language-based LD's on recidivism was how it impaired understanding of emotional communication from others.

The authors also highlighted "[T]he impulsiveness of the ADHD individual" and its possible impact, leading them "to engage in a variety of criminal acts, not thinking through the consequences of their behavior" (at page 19).

Insightfully, the authors point out that "[T]he important distinction between psychopathy versus ADHD and brain dysfunction *is that the latter have treatment paths* whereas psychopathy has no effective treatment." (Italics added for emphasis).

The authors cite a 2000 article by Richardson who concluded that "a comprehensive treatment plan for ADHD is important in reducing recidivism" (at page 21).
Also quite poignant was the authors citation of a study[28] which "noted that neuropsychologically impaired children are the least likely to be in environments that would help them adapt to their handicaps." Colton's home environment was anything but helpful.

It is unfortunate that at the time of Colton's JRA placement at Griffin House, which preceded the subject offenses, an adequate assessment of his neurocognitive status had not been conducted.

Even a straightforward review of his educational records, for which a Release of Information was signed, would have identified risk factors for recidivism and could have lead to interventions to ameliorate them.

Most notably, records from JRA do not reflect any appreciation of the existence of a Mathematics Learning Disorder (LD) or Colton's history of language-based LD.

The language-based problems identified by Dr. Beaver are very likely the very same ones identified at age 3 and inadequately addressed by school personnel.[29]

Colton's prior history of being diagnosed with ADHD and treatment records reflecting a prior positive response to medication (i.e. Strattera) were not known by the JRA-based treatment team.

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[28] Moffitt TE, Caspi A. Childhood predictors differentiate life-course persistent and adolescent-limited antisocial pathways among males and females. Development and Psychopathology. 13: 355 – 375, 2001.

[29] Johnson CJ, Beitchman JH, Young A, et al. Fourteen-Year Follow-UP of Children With and Without Speech/Language Impairments: Speech/Language Stability and Outcomes. J Speech, Language and Hearing Research. 42: 744 – 760, 1999.

These omissions likely contributed to Colton eloping from his JRA placement at Griffin Home and the unfortunate chain of events that followed.

With regard to "criminal versatility" it is worth repeating that Colton has not committed any violent or sexual offenses. Even within his pattern of offenses, there is a relatively narrow pattern which primarily revolves around breaking and entering.

Another highly relevant study involved 378 young male offenders who were psychiatrically-evaluated while in an unlocked group facility (similar to Griffin Home). [30] They ranged in age from 16 to 24 years old. They were followed for an average of 8.7 years. This study addressed subsequent charges, and was not limited to convictions.

There was an incidence of nearly 12% of Learning, Communication and Tic Disorders in those young persons receiving juvenile rehabilitative services.

Young people with multiple (i.e. co-occurring) psychiatric disorders (like Colton has) had a lower rate of all adult offense types combined including a lower rate of adult drug offenses. The presence of mood disorders and learning/communication disorders decreased the rate of all adult offenses combined.

Relative to the kind of crime Colton *has* committed (that is, property crimes), the presence of a substance abuse/dependence diagnosis and personality disorders (as well as personality "defects" and "deprivation syndrome") contribute to risk for recidivism. Substance abuse/dependence was the main risk factor for escaping custody and what the study termed "breaches" (institutional infractions).

The relevance of this study's findings for Colton's case is that early identification and active, effective treatment of young people with complex psychiatric problems has a very positive impact on recidivism. Given Colton's present age the study findings would still apply to him at present and they argue for a treatment -focused, versus punitive approach to his sentencing.

[30] Bevc I, Duchesne T, Rosenthal J et al. Young Offenders' Diagnoses as Predictors of Subsequent Adult Criminal Behavior. Presentation at the 111th Annual Convention of the American Psychological Association, Toronto, Canada, August 7, 2003.

From this perspective, the "silver lining" for some of Colton's recidivism-related risk factors is that three of them have treatment paths. They are amenable to readily-available intervention. In particular, the three are:

1. Learning Disorder (Math, Expressive Language),
2. Diagnosis of ADHD (medication, accommodations, learning strategies),
3. Years of education attained.

RECOMMENDATIONS:

1. The findings of this evaluation should be reviewed with Colton, including provision of the report when deemed clinically appropriate.
2. It is recommended that this evaluation be provided to all relevant correctional personnel working with Colton.
3. Institutional placement should be made taking Colton's identified needs into account (e.g. psychiatric medication
4. Colton should be seen for medication management, particularly for his attentional symptoms and appropriate trials should be followed by reliable outcome measures such as rating sheets and/or computerized tests of attention/impulsivity. According to the existing professional literature, it is likely that he will have some meaningful response to medication. If stimulant medications are not available to him due to institutional policy, there are non-stimulant options that should not be overlooked, including Strattera, Wellbutrin, Effexor, and Intuniv).
5. Colton's 2001 elevated thyroid test (T3 Total) should be followed up with a full thyroid function panel.
6. Colton's prior history of abuse and PTSD should be kept in mind if he is further traumatized and/or victimized. Persons with such histories have an increased risk for subsequent PTSD.
7. Colton should be provided with a formal Speech and Language Evaluation and remediation as indicated.
8. A physical examination should be conducted to definitively address the provisional diagnosis of Alcohol-Related Neurodevelopmental Disorder. The medical work up should be augmented by inventories of adaptive functioning completed by several reliable reporters (i.e. Vineland Adaptive Behavior Scales – II). An MRI might be of value to explore the possible structural impact of prenatal alcohol.
9. Colton should have individual therapy as available to address his emotional issues and concerns.
10. Colton should have a formal evaluation for substance abuse and treatment as indicated. He has a prominent family history (and thus genetic risk factors) for this. His MMPI-2

data raises concerns about his potential for substance abuse. The ability to stay off drugs and alcohol greatly contributes to an improved prognosis.

11. Colton's progress should be followed by intermittent administration of the MMPI-2.
12. Educational planning and opportunities should be informed by the test result findings. Colton's Mathematics Learning Disorder will require Remediation. Educational attainment should be encouraged.
13. Colton should be provided with positive role models as much as possible.
14. Colton's positive attributes and accomplishments should be acknowledged.

PROGNOSIS:

As stated above, Colton's overall prognosis is good assuming that the identified remediable issues are actively and effectively addressed. Given his neuropsychological impairments, which are consistent with ARND, adequate long-term structure, guidance and reasonable supervision will enhance his life's trajectory (both in and out of correctional settings).

Thank you for permitting me to evaluate Colton. I hope I have answered the consultative questions in a complete and readily understandable fashion. If you have questions or concerns, please do not hesitate to contact me.

Respectfully submitted,

Richard S. Adler, M.D.

Attachments

Paul D. Connor, Ph.D.
Neuropsychological Assessment Services
22517 7th Avenue South
Des Moines, WA 98198
206-940-1106 Fax 206-870-9081
www.connorneuropsychology.com
paul@connorneuropsychology.com

27 September 2011

Richard Adler, M.D.
1700 7th Ave. #210
Seattle, WA 98101

Re: Review of neuropsychological report by Craig Beaver, Ph.D. pertaining to Colton Harris-Moore

Dr. Adler,

Per your request, I have reviewed Dr. Beaver's neuropsychological report on the assessment he did with Colton. Dr. Beaver's conclusion was that though Colton was demonstrating deficits in a number of areas, he did not feel that Colton's functioning met criteria for FASD based on the CDC's guidelines. However, based on my review of the testing and report, it is my opinion that Colton's pattern of functioning is consistent with the CDC's criteria for CNS dysfunction with respect to FASD as, based on the test data provided by Dr. Beaver, Colton demonstrates deficits in 4 domains of functioning.

1. With respect to deficits in academic functioning, though he does not demonstrate current academic deficits, Colton's performance on past standardized testing (Iowa Test of Basic Skills) was within the impaired range. On that testing, he scored at the 13th percentile in arithmetic. This is often the most significantly impaired of the academic skills in individuals with FASD. Furthermore, he was involved with special education from an early age, also indicating academic deficits.

2. On attention measures, as Dr. Beaver indicated overall performance was essentially within normal limits. However, Colton was demonstrating subtle but significant deficits in impulsivity (an atypically fast reaction time and deficits in his ability to discriminate between stimuli) and variability of attention functioning (especially when the stimulation level was suboptimal).

3. On current testing, Colton demonstrates deficits in memory functioning. This is evidenced by deficits in immediate and delayed recall on visual memory tasks and on immediate memory functioning in general.

4. Colton demonstrates deficits in a number of areas within the domain of executive functioning. Deficits were found in verbal fluency or generation of ideas (the most

significantly impaired aspect of his functioning), developing and maintaining problem solving strategies, some portions of working memory functioning, and in his ability to inhibit well learned behaviors. Indeed, the majority of the deficits found on current testing are considered to be measures of aspects of executive functioning or executive control.

Furthermore, historical information reported by Dr. Beaver indicated a number of things that are also consistent with a history of FASD. These included evidence of early delays in reaching developmental milestones, prior diagnosis of ADHD, and the previously mentioned involvement with special education services.

In conclusion, though the pattern of Colton's neuropsychological deficits may be relatively subtle in several areas, in my opinion, the breadth of these deficits is consistent with research on individuals with FASD and with the guidelines developed by the CDC for the diagnosis of FASD.

Thank you for the opportunity to review this case.

Sincerely,

Paul D. Connor, Ph.D.
Licensed Psychologist/Neuropsychologist

RICHARD S. ADLER, M.D.

Forensic & Clinical Psychiatry

1700 Seventh Avenue, Suite 210

Seattle, WA 98101

(206) 624 - 3800•OFFICE

(206) 624 - 3801•FAX

EDUCATION

1998 – 2000	**Senior Fellow in Forensic Psychiatry** University of Washington School of Medicine Seattle, WA
1986 - 1988	**Fellow in Child Psychiatry** Massachusetts General Hospital /Harvard Medical School Boston, MA 02114
1984 - 1986	**Resident in Adult Psychiatry** McLean Hospital/Harvard Medical School, Belmont, MA 02478 *Included rotations in Consult - liaison* *Psychiatry at Brigham & Women's Hospital,* *Adolescent and Family Treatment Unit at McLean* *Hospital*
1983 - 1984	**Internship year in Adult Psychiatry** McLean Hospital/Harvard Medical School *Six months medical internship at Mt. Auburn* *MGH, two months of Inpatient Geriatric Psychiatry,* *two months of Substance Abuse Psychiatry*
1978 - 1983	**Albany Medical College of Union University (AMC)** Albany, NY 12208 Doctor of Medicine *Alpha Omega Alpha Honor Society* *Shaeffer Prize in Pathology* *Honor Committee Member 1978 - 1980*
1980 - 1981	**Research in Gastrointestinal Pathology**

Brigham and Women's Hospital
Department of Pathology, Ramzi Cotran, M.D., Chief
Boston, MA 02115
American Gastroenterological Association Award for Medical Student Research - Poster Presentation

1976 - 1982 **Rensselaer Polytechnic Institute (RPI)**
Troy, NY 12180
Bachelor of Science in Biology
Summa cum laude, RPI - AMC 6-year Biomedical Program

POSITIONS

5/08 – present **Medical Director**
FASD Experts.com - Interdisciplinary collaborative forensic and clinical evaluation of Fetal Alcohol Spectrum Disorders

2/97 - present **Private Practice**
Forensic and clinical psychiatric practice in child and adult psychiatry

2007 – present **Clinical Instructor**
University of Washington School of Medicine
Seattle, WA

2007 – present **Clinical Instructor**
Antioch University Seattle
2326 6th Ave, Seattle, WA 98121

3/00 - present **Speakers Bureau and National Advisory Board**
McNeil Consumer Healthcare, makers of Concerta ®

2006 - 2008 **Psychiatric Consultant**
Renton Academy
Employed by the Renton School District to provide on-site psychiatric services for a new specialty school informed by the Re-Education Approach pioneered by Nicholas Hobbs, Ph.D.

2006 **National Advisory Panel**
Cephalon, Inc., makers of Sparlon ® (modafanil)

2/97 - 6/08 **Staff Psychiatrist**

Children's Hospital & Medical Center
Seattle, WA
Patient evaluation and psychopharmacologic management, team consultation two days a week

7/00 – 12/00 **Staff Psychiatrist**
Western State Hospital
Program for Forensic Evaluations in Corrections and the Community,
Tacoma, WA 98498
Carl Redick, Psy.D., Director

7/98 – 6/00 **Acting Clinical Instructor (*)**
Children's Hospital & Medical Center, Lake City Way Satellite
(206) 368-4949
Individual and group supervision of Child Psychiatry Fellows, Adult Psychiatry Residents, Psychology Interns at a University of Washington Medical School teaching site.

(*) During the Senior Fellowship in Forensic Psychiatry (see Education), University of Washington regulations require that the instructorship be regarded as "acting".

1/98 - 7/98 **Clinical Instructor**
Children's Hospital & Medical Center, Lake City Way Satellite

8/96 - 6/98 **Staff Psychiatrist**
Seattle Mental Health Institute, 1600 East Olive Street,
Seattle, WA 98122. (206) 324-2400
Provided staff consultation and treatment to adults, children and adolescents, including The Deaf Services unit, in a large CMHC with a wide continuum of care.

8/91 - 7/96 **Medical Director & Founding President**
Comprehensive Psychiatric Group, 120 East Main Street,
Salisbury, MD 21801.
Region's largest multi-disciplinary mental health practice with Addictions, Eating Disorders and extensive Group Psychotherapy Programs.

3/95 - 7/95	**Consultant - Behavioral Health Services** Peninsula Regional Medical Center (PRMC) 100 East Carroll Street, Salisbury, MD 21801 *Retained to design integrated and managed care-friendly inpatient, outpatient, consult-liaison and emergency mental health services.*
1/94 -12/95	**Community Affiliate, Peninsula Regional Medical Center**
11/91-12/93	**Attending Psychiatrist,** Peninsula Regional Medical Center *Inpatient, emergency and consult - liaison services*
7/88 - 6/92	**Medical Director, Mental Health Clinic** Somerset County Health Department, Westover, MD 21871 *National Health Service Corps Scholarship Placement. Included consultation to Colbourne Substance Abuse Center, Crisfield, MD & Somerset County Sheriff's Department, Public Schools, and Developmental Center.*
7/88 - 6/91	**Medical Director, Mental Health Clinics** Worcester County Health Department, Snow Hill, MD 21863. *National Health Service Corps Scholarship Placement*
7/86 - 6/88	**Part-time private practice** Boston, MA
10/86 - 6/88	**Ciba-Geigy Clinical Trial of Clomipramine for Obsessive-Compulsive Disorder in Children and Adolescents.** Massachusetts General Hospital, Boston, MA *Co-investigator with Joseph Biederman, M.D.*
1986 - 1990	**Doctor-on-Call** Pembroke Hospital, Pembroke, MA *150 bed Private Psychiatric Hospital*
1985 - 1990	**Doctor-on-Call** Norwood Hospital, Norwood, MA *21 bed locked psychiatric unit in a suburban community General hospital with Emergency Room and Consult-liaison consultation services.*

1985 - 1986 **Psychopharmacology Consultant**
Cutler Counseling Center, Norwood, MA
Non-profit, community outpatient facility

LICENSES

1996 -	Washington	33536	(3/12/96)
1988 - 1996	Maryland	D36903	(6/18/88)
1984 - 1991	Massachusetts	54358	(6/l/84)

CERTIFICATIONS

1992 **Child and Adolescent Psychiatry**
American Board of Psychiatry and Neurology, #2903

1990 **Adult Psychiatry**
American Board of Psychiatry and Neurology, #33030

1984 **National Board of Medical Examiners**, #262751

MAJOR COMMITTEE ASSIGNMENTS

2005 - **Chairman, Ethics Committee**
Washington State Psychiatric Association

1998 **Managed Care Committee**
Division of Child & Adolescent Psychiatry, Children's Hospital and Regional Medical Center, Seattle, WA

1995 **Representative of the Maryland Psychiatric Society to the Rural Psychiatry Task Force**
American Psychiatric Association Annual Meeting
May, Miami Beach, FL

1992 - 1996 **Board of Directors**
Life Crisis Center, 216 East Main Street, Salisbury,
Chairman, Executive Director Search Committee (1994)

1993 **Select Committee, Quality Council**
Peninsula Regional Medical Center
Empowered to re-engineer Emergency Room Psychiatric Services. Developed satisfaction assessment tool

1992 - 1993	**Utilization Review Committee** Peninsula Regional Medical Center
1991 - 1993	**Founding President** Eastern Shore Psychiatrists' Group *Established to provide networking opportunities*
1991	**Physicians' Steering Committee** Atlantic General Hospital, Berlin, MD *Providing input on design of new community General hospital*
1988 - 1992	**Utilization Review Committee** Peyton Psychogeriatric Unit McCready Hospital, Crisfield, MD *Specialty in-patient locked unit for chronically mentally ill geriatric patients*

MEMBERSHIPS

1996 -	American Academy of Psychiatry and the Law
1984 -	American Psychiatric Association
1991 - 1996	Eastern Shore Psychiatrists' Group
1988 - 1996	Maryland Psychiatric Society
1986 - 1988	Massachusetts Psychiatric Society

PUBLICATIONS & PRESENTATIONS

2011	**"UW School of Law Presents: Fetal Alcohol Spectrum Disorders and the Criminal Justice System."** King County Courthouse. March 1, 2011. Presentation with Mr. Rod Snow, President, Canadian Bar Association.
2010	**"Fetal Alcohol Spectrum Syndrome: Its Relevance Throughout the Legal Process From Competency to Stand Trial to Clemency,"** Adler RS, Novick Brown N, 2010 Appellate Judicial Attorneys Institute, Administrative Office of the Courts: Education Division. Burlingame, CA. October 27, 2010. www2.courtinfo.gov
2010	**"Violence Risk Assessment in 2010: State of the Art as Seen Through a Wide Lens,"** Adler RS, Heavin S, McMinimee S. 2010 Oregon-Washington Bi-State School Psychology Conference. Vancouver, WA. October 14, 2010. www.WSASP.org

2010 **"Creating a Tomorrow: Post-Mortem on a Death Verdict."** Panel Member/Faculty, Full-day Continuing Legal Education Program, Washington Death Penalty Assistance Center. Seattle, WA. September 22, 2010.

2010 **"Fetal Alcohol Spectrum Disorder in the Courtroom: The 20th Anniversary of Dr. Ann Streissguth at Airlie,"** (Plenary Session). Adler RS, Kase KM, Kelly K, Novick Brown N. NAACP Legal Defense Fund 31st Annual Meeting. Airlie Conference Center, Warrenton, VA. July 10, 2010.

2010 **"FASD: Practicalities,"** (Breakout Session). Novick Brown N, Adler RS, Kase KM, Kelly K. NAACP Legal Defense Fund 31st Annual Meeting. Airlie Conference Center, Warrenton, WA. July 10, 2010.

2010 **"Forensic Assessment of Fetal Alcohol Spectrum Disorders with State-Of-The-Art Facial Analysis, Diffusion Tensor Imaging, and MRIs,"** (Plenary Session). Adler RS, Novick Brown N, Connor PD, Wartnik AP. Habeas Assistance & Training Counsel Project, Seventh National Seminar on the Development and Integration of Mitigation Evidence: "New Science, New Strategies." Seattle, Washington, April 22, 2010.

2010 **"Suggestibility in FASD: Forensic Assessment and Implications,"** Adler RS, Novick Brown N, Connor PD, Wartnik AP. 4th National Biennial Conference on Adolescents and Adults with Fetal Alcohol Spectrum Disorder: Facing the Future Together: Where Do We Go From Here?. Vancouver, B.C., Canada. April 17, 2010

2010 **"FASD: Application of the Scientific Method to the Forensic Setting."** Adler RS, Novick Brown N, Connor PD. Texas Criminal Defense Lawyers Association Annual Capital Trial/Habeas Seminar. Austin, Texas. February 25, 2020.

2010 **"Fetal Alcohol Syndrome: Practical Tools,"** Adler RS, Novick Brown N, Connor PD, Wartnik AP. 3rd Interdisciplinary Program, University of Washington School of Law & The Washington Death Penalty Assistance Center: Expertise You Need To Defend A Capital Case In 2010. Seattle, WA. February 6, 2010.

2009 **"Testamentary Capacity: Why, When and How to Use a Mental Health Expert."** King County Bar Association. 12th Annual Probate, Trust and TEDRA Litigation Conference. Rainier Square Conference Center, Seattle, WA. December, 4, 2009.

2008	**"Fetal Alcohol Spectrum Disorder in the Educational Context"** Lake Washington School District – In Service. October 24, 2008
2008	**"Vetting The Expert: Why, When and How"** & **"Bringing It All Home"** (the latter co-presented with Seattle attorney Jeff Robinson of Shroeter, Goldmark and Bender). TeamChild Benefit CLE" Collaboration Between Attorneys and Mental Health Experts: Beyond the Basics. Seattle, WA. October 3, 2008. www.teamchild.org.
2007	**"Parenting Evaluations – A Critical Review and Practice Skills"** Washington State Bar Association – Continuing Legal Education Washington State Convention and Trade Center. Seattle, WA. August 8, 2007 and Doubletree Inn, Suite B, Spokane, WA, August 21, 2007. www.wsbacle.org
2004 & 2006	**"How to Help Your Client Survive a Parenting Evaluation in Washington"** National Business Institute Seminar, Washington State Convention and Trade Center, Seattle, WA. November 5, 2004, November 10, 2006. www.nbi-sems.com
2002	**"Child Abuse and Neglect"** Western State Hospital Forensic Seminar Series, Greg Gaggliardi, Ph.D., Seminar Director.
2000	**"Pediatric Psychopharmacology: The Cutting Edge"** Washington State and British Columbia Associations of School Psychologists Fall Conference, Vancouver, B.C.
1999	**"Pediatric Psychopharmacology: The Cutting Edge"** Child and Adolescent Neuropsychiatry Conference, Children's Hospital and Regional Medical Center, Seattle, WA
1998	**"The Broad Bandwidth of Autism Spectrum Disorders"** Child and Adolescent Neuropsychiatry Conference, Children's Hospital and Regional Medical Center, Seattle, WA
1997	**"No Need to Panic: Anxiety Disorders Update for the Clinician."** Child and Adolescent Neuropsychiatry Conference, Children's Hospital and Regional Medical Center, Seattle, WA

1991 **"The Transition from Resident to Medical Director",** American Psychiatric Annual Meeting, Course: Administration in Austerity. Paul Rodenhauser, M.D., Course Director.

1990 Adler RS, Jellinek MS. **Special Article: "After Teen Suicide: Issues for Pediatricians Who Are Asked to Consult to Schools".** Pediatrics. 86:6, 982 - 7.

1990 Adler RS. **Out-of-Control Behavior.** The Massachusetts General Hospital: Psychiatric Aspects of General Hospital Pediatrics. Jellinek MS, Herzog DB, Eds. Chicago: Year Book Medical Publishers, pp. 298-304.

1990 Adler RS, Jellinek M. **Suicide.** Ibid. pp. 324 - 30.

1985 Adler RS, Nafradi J, Szabo S. **"Cysteamine-induced Duodenal Ulcer is not Site-specific: Effect of Local Modulating Factors".** J. Experimental Pathology 2:2, 111-22.

1983 Adler RS, Gallagher GT, Szabo S. **"Duodenal Ulcerogens Cysteamine and Proprionitrile Decrease Duodenal Neutralization of Acid in the Rat".** Digestive Diseases and Sciences 28:8, 716-23.